UNITED REGIONAL HEALTH CARE SYSTEM
11TH
36-24-04 |N|
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
		mom	MOMS[illegible] RN		
		(R)	Renée [illegible] R		

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0720		Pt received for care. Physical Assessment completed see flow sheet. Pt is sedated & paralyzed. Pt is orally intubated & on vent. Pt see settings. Resp are even & Bilateral wheezes throughout. NG tube is in place & currently is to suction. Rectal tube is in place. IV solutions & rates verified. Cardiac Monitor shows sinus tach cardiac. Guards are @ bedside pt has ankle shackles in place.
0800		Pt repositioned on right side. Mouth care completed pt noted to have bloody secreations. — mom
0900		Am medications given. — mom
0930		Family members are at bedside. — mom
1030		Dr Mamdani [illegible] orders received — mom
1200		Breath sounds continue to have wheezes bilaterally. [illegible] dopamine down. — mom
1400		Pt Status is unchanged. — mom
1600		Pt to CT Scan accompanied by Staff & guards. — mom
1825		I/O calculated. Mouth care completed. Status is essentially unchanged. — mom
1920	PM ASSESSMENT	Pt. in bed sedated and paralyzed c̄ Diprivan and Nacuron. Repositioned for comfort. Guards @ BS x3. Soft wrist restraints on bilat wrists - CMS intact, Released while repositioning. Shackels to bilat ankles. Guards loosened per request d/t ting gen. edema. VSS. O2 sat is 92% via ETT/vent. ECG tracing ST c̄ ectopy. Temp @ 99[2]. Cool Blanket in use. Lungs have some wheezes / Rhonchi present. Sm. amt. received when suctioned. Oral care provided. PERRLA. (L) eyes sl. Ø movement to extremities. BS Ø hypoactive. [illegible] air bolus. All pulses palp. [illegible] ↑ in pillows. [illegible] IV fluids infusing c̄ difficulty to @ [illegible] [illegible] to @ AC [illegible] HOB & SRS ↑. [illegible] to monitor

UNITED REGIONAL HEALTH CARE SYSTEM

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Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time	0920		1920	2230							
O2 via	vent		vent	vent							
L/M or FIO2	50	45	45	50							
(CMV/SIMV Rate	16		16								
Vt	750		750								
CPAP / PEEP			0								
PSV			↓								
PCV											
DS			↓								

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn		✓		✓		✓		✓		✓			(R)		(R)		(R)		(R)		(R)		(R)	
CDB																								
TED Care																								
Bath/Shower																							(N)	
Mouth Care		✓		✓	=	✓		✓		✓		✓	(N)		(N)				(N)		(N)		(N)	
Foley Care																							(N)	
Trach Care																								
Oral/Naso/Trach/ETT Suctioning													ETT		oral				oral	ETT			oral	ETT
Sputum Amount (Sm/Mod/Lg)													Sm		Mod				Sm				Sm	
Consistency (Th = Thick/T =)													T		T				T				T	
Color													Yell		Yell-Bloody				Yell Bloody				Yell Bloody	
HOB degree													30°	—	30°									

NGT			IV INSERTION					IV SITE CARE			IABP/A-LINE DC'd		EQUIPMENT	
Tube Type			Site					Site			By		IV Pump	✓
Size			Gauge					Patent			Time		Feed Pump	
By			By					Drsg Applied			Bleeding		Oximeter	✓
Time			Time					By			Hematoma		Ventilator	✓
Placement 'd			Start Kit Used					Time			Site Clean		Temp Pace	
X-Ray			Injection Site					DRAIN DC'd			Pressure Drsg		SCD/K Ped	
To Suction			# Attempts					Type			CMS adequate		Bard	
Clamped			IV DC'd					Site			PA CATHETER DC'd		IABP	
Feeding			Site					Drsg Applied			By		Camino	
D/C'd Time			Redness					By			Time		Geomatt	
FOLEY/STRAIGHT CATH			Bleeding					Time			Ectopy		Hypo/Hyper Thermia Unit	✓
Size			Drainage					CT DC'd			EXTUBATION			
Sterile Tech. Used			Infiltration					Site			Hyperoxygenated			
By			Drsg Applied					By M.D.			Suctioned			
Time			By					Drsg Applied			Extubated by			
D/C'd Time			Time					Time			Time			

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		—
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.		AM	PM
*Requires Further Charting	*Alternative		
Tube Wandering Fall	*Measures		
Aggressive/Assaultive	Time Applied		✓
	Type: Wrist	X2	X2
	Vest		—
	4 pt.		—
✓ Done-Continues	Needs Attended Q 2 hr	✓	✓
	per protocol:	✓	✓
	*Time Discontinued		
Report given to next shift		✓	✓

27-12

UNITED REGIONAL HEALTH CARE SYSTEM
11TH
36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

ATIENT CARE RECORD - OBSERVATIONS
SPECIALTY CARE
Form # 8330/03 (REV. 12/99)

CODE STATUS Full
ALLERGIES: NKA

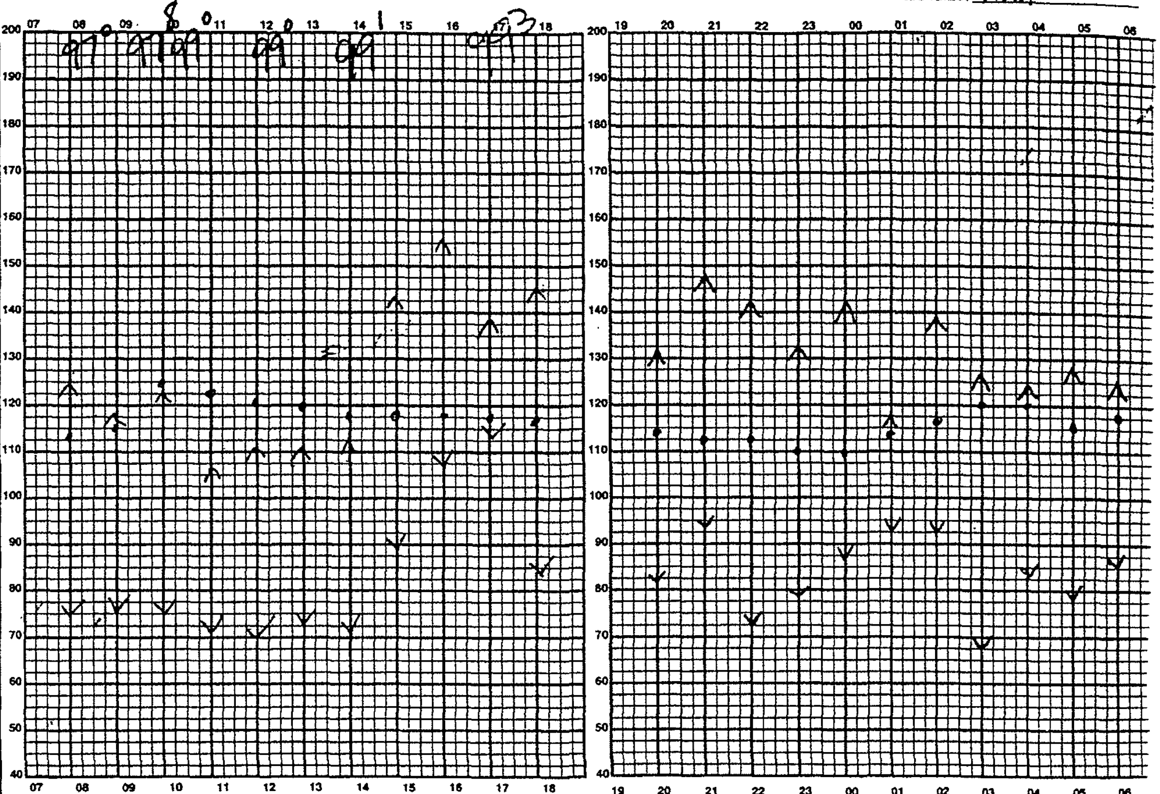
GLASGOW COMA SCALE

EYE OPENING	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensive Words	2
	None	1
MOTOR RESPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws (Pain)	4
	Flexion (Pain)	3
	Extension (Pain)	2
	None	1

PUPILS (cm) 1, 2, 3, 4, 5, 6, 7, 8

EXTREMITIES
STRENGTH (Grips)
3 - Strong
2 - Fair
1 - Weak
0 - Absent

PULSES
P = Palpable
D = Doppler
P1 - Weak
P2 - Fair
P3 - Strong
D1 - Monophasic
D2 - Biphasic
D3 - Triphasic



	07	08	09	10	11	12	13	14	15	16	17	18
Respirations		20	20	20	20	20	20	20	20	20	20	20
O2 Sat %		93	92	90	90	89	90	92	93	92	90	91
HEMODYNAMICS CO/CI												
CVP/PCWP												
PAP												
SVR/PVR												
NUERO Eye Opening		1				1					1	
Verbal Response		EK1				ETT1					ETT1	
Motor Response		1				1					1	
Total (≥ 7 indicates coma)		3				3					3	
Pupils L		4										
Pupils R		4										
Extremities Arm L		0										
Extremities Arm R		0										
Extremities Leg L		0										
Extremities Leg R		0										
PULSES Time	0800											
Radial L	P2											
Radial R	P2											
Dorsalis Pedis L	P2											
Dorsalis Pedis R	P2											
Posterior Tibial L	P1											
Posterior Tibial R	P1											

	19	20	21	22	23	00	01	02	03	04	05	06
		98.8	98.2		97.6	97.0	96.6		99.3	100.0	99.8	99
Respirations		20	20	20	20	20	20	20	20	20	20	20
O2 Sat %		93	93	90	92	91	90	90	90	91	90	90
HEMODYNAMICS CO/CI												
CVP/PCWP												
PAP												
SVR/PVR												
NUERO Eye Opening		1		1		1				1		
Verbal Response		ETT1		ETT1		ETT1				ETT1		
Motor Response		1		1		1				1		
Total (≥ 7 indicates coma)		3		3		3				3		
Pupils L		SR4				SR4				SR4		
Pupils R		SR4				SR4				SR4		
Extremities Arm L		0				0				0		
Extremities Arm R		0				0				0		
Extremities Leg L		0				0				0		
Extremities Leg R		0				0				0		
PULSES Time		1945				0000				0415		
Radial L		P2				P2				P2		
Radial R		P2				P2				P2		
Dorsalis Pedis L		P2				P2				P3		
Dorsalis Pedis R		P3				P3				P2		
Posterior Tibial L		P1				P1				P1		
Posterior Tibial R		P1				P1				P1		

DATE 7/20/01 ROOM# SC118

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

95 kg

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: ______ Current Wt.: ______

*Residuals are not included in the I & O unless discarded
‡ Indicate with 'V' the first void after d/c of Foley
§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

Hour	Soln Site: NS ① SC distal (cc/dose)	Soln Site: Dopamine ② SC medial (cc/dose)	Soln Site: PPN ① SC Prox (cc/dose)	Soln Site: Norcuron ② SC medial (cc/dose)	Soln Site: Diprivan ① SC prox (cc/dose)	Soln Site (cc/dose)	Soln Site (cc/dose)	Soln Site (cc/dose)	Soln Site (cc/dose)	Soln Site (cc/dose)	Soln Site	Tube Feeding	PO	Meds Flush	Rectal enemas	Hourly / Sub Total	Resid*
07	10	8.9	150	8/	3/								NPO				
08														25 30	60		
09																	
10																	
11		54				250cc bolus								30	60		
12																	
13																	
14																	
15																	
16														20 30	60		
17																	
18																	
TOTAL	61	54	1756	92	37	250								135	180		

TOTAL 12 INTAKE 3115

Hour	Urine ‡	NGT	Rectal				
07							
08	400						
09	250						
10	150						
11	100						
12	175						
13							
14	325						
15	115						
16							
17	250						
18	130						
TOTAL	1845	100	450				

TOTAL 12 OUTPUT 2445

Hour	NS c IVPB	CPN	[illegible]	Norcuron								Tube Feeding	PO	OGT	RT	Hourly / Sub Total	Resid*
19	20/	150/	3/5.2	8/0.28 mcg									(NPO)				
20			6/10.5											60	120		
21																	
22																	
23																	
00			4.5/7.8 mg	10/0.35 mcg										60	120		
01																	
02																	
03			10/17.5														
04														60	120		
05																	
06																	
TOTAL	278	1786	88	106										180	360		

TOTAL 12 INTAKE 2798

Hour	Urine ‡	OGT	RT				
19							
20	350+		50				
21							
22	350+						
23							
00	/1000		150				
01							
02	350+						
03							
04	350+		200				
05							
06	/1100	/150	/600				
TOTAL	2100	150	600	27-124			

TOTAL 12 OUTPUT 2850

TOTAL 24° INTAKE 5913 **TOTAL 24° OUTPUT** 5295 **24° VARIANCE** (+618)

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Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
[illegible]	[illegible] RN				
(R)	Renee [illegible] RN				

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment
0800	[illegible]		Unresponsive	sedated				
1945	(R)		paralyzed / sedated	ō Diprivan / Norcuron				

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0800	Seizure precautions	Rec'd rpt from previous shift - see nurses flow sheet for complete assessment. Sedated on Diprivan & Norcuron gtt TOF 4/4 attempts; pupils equal & slow react; lungs ē coarse lung sounds bilat; ST ⊘ ectopy; gen edema; pulses pal; soft wrist restraints bilat instead of shackles - shackles to both ankles, legs slightly elevated to relieve pressure from restraints - skin abrasion noted to (R) lateral ankle approx 2 wide x 2cm long; guards @ bedside ——— [illegible]
1000		Becomes agitated easily ē stim & quiets quickly; O2 sat ↓ 88 @ these times; pt cont to breathe in sync ē vent; ST ⊘ ectopy ——— [illegible]
1200		Bolus of 500cc NS started @ 1100 in ē diff in apparent condition VS per flow sheet; resident doctor [illegible] updated - aware of increasing abd girth & firmness - no new orders rec'd @ this time ——— [illegible]
1400		VSS; cont to breath in sync ē vent; Dr Chap. called bld gases by RT & new orders rec'd → 1 amp NaHCO3 given per new orders ——— [illegible]
1500		Dr [illegible] notified of ↑ diastolic pressure 154/108 → pt assessed & no new orders rec'd ——— [illegible]
1700		No Δ in assessment; becomes agitated for short periods of time when repositioned ∠ 1-2 min; cont to breath in sync ē vent ——— [illegible]
1945	PM Assessment	Pt. in bed sedated and paralyzed ē Diprivan / Norcuron gtts. Guards @ BS x 3. Pt. using abdominal muscles to breathe. Slightly agitated. ↑ed Diprivan gtt to 10 mcg. Reported [illegible] skin breakdown noted to [illegible] buttocks (split). Protective ointment applied. Pupils @ 4R (sluggish). Pt. twitches 3

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Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time	0800	1200
O2 via	vent	vent
L/M or FIO2	50	60
CMV/SIMV Rate	20	20
Vt	750	800
CPAP / PEEP	5	0
PSV		
PCV		
DS		
FB		

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn		R		L		B		R		B				P		W		P		P		P		
CDB																								
TED Care																								
Bath/Shower																								
Mouth Care		✓		✓		✓		✓		✓				W		W		W		P		P		
Foley Care																								
Trach Care	NA																							
Oral/Naso/Trach/ETT Suctioning														ETT		oral		oral				oral		
Sputum Amount (Sm/Mod/Lg)														Ø		Sm		Sm				Sm		
Consistency (Th = Thick/T =)																T		T				T		
Color																yel blood tinged		Sang				Sang		
HOB degree		20°				30°		30°						30°										

NGT			IV INSERTION			IV SITE CARE			IABP/A-LINE DC'd			EQUIPMENT		
Tube Type			Site			Site			By			IV Pump		X5
Size			Gauge			Patent			Time			Feed Pump		
By			By			Drsg Applied			Bleeding			Oximeter		✓
Time			Time			By			Hematoma			Ventilator		✓
Placement 'd			Start Kit Used			Time			Site Clean			Temp Pace		
X-Ray			Injection Site			DRAIN DC'd			Pressure Drsg			SCD/K Ped		
To Suction			# Attempts			Type			CMS adequate			Bard		
Clamped			IV DC'd			Site			PA CATHETER DC'd			IABP		
Feeding			Site			Drsg Applied			By			Camino		
D/C'd Time			Redness			By			Time			Geomatt		
FOLEY/STRAIGHT CATH			Bleeding			Time			Ectopy			Hypo/Hyper Thermia Unit		✓
Size			Drainage			CT DC'd			EXTUBATION					
Sterile Tech. Used			Infiltration			Site			Hyperoxygenated					
By			Drsg Applied			By M.D.			Suctioned					
Time			By			Drsg Applied			Extubated by					
D/C'd Time			Time			Time			Time					

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.		AM	PM
*Requires Further Charting	*Alternative		
Tube Wandering Fall	*Measures		
Aggressive/Assaultive	Time Applied	Cont	Cont
	Type: Wrist	X2	X2
	Vest		
	4 pt.		
✓ Done-Continues	Needs Attended Q 2 hr	✓	✓
	per protocol:		✓
	*Time Discontinued		
Report given to next shift		✓	✓

27-130

UNITED REGIONAL HEALTH CARE SYSTEM

11TH

36-24-04 |N|

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DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

ATIENT CARE RECORD - OBSERVATIONS

SPECIALTY CARE

Form # 8330/03 (REV. 12/99)

CODE STATUS Full
ALLERGIES: NKA

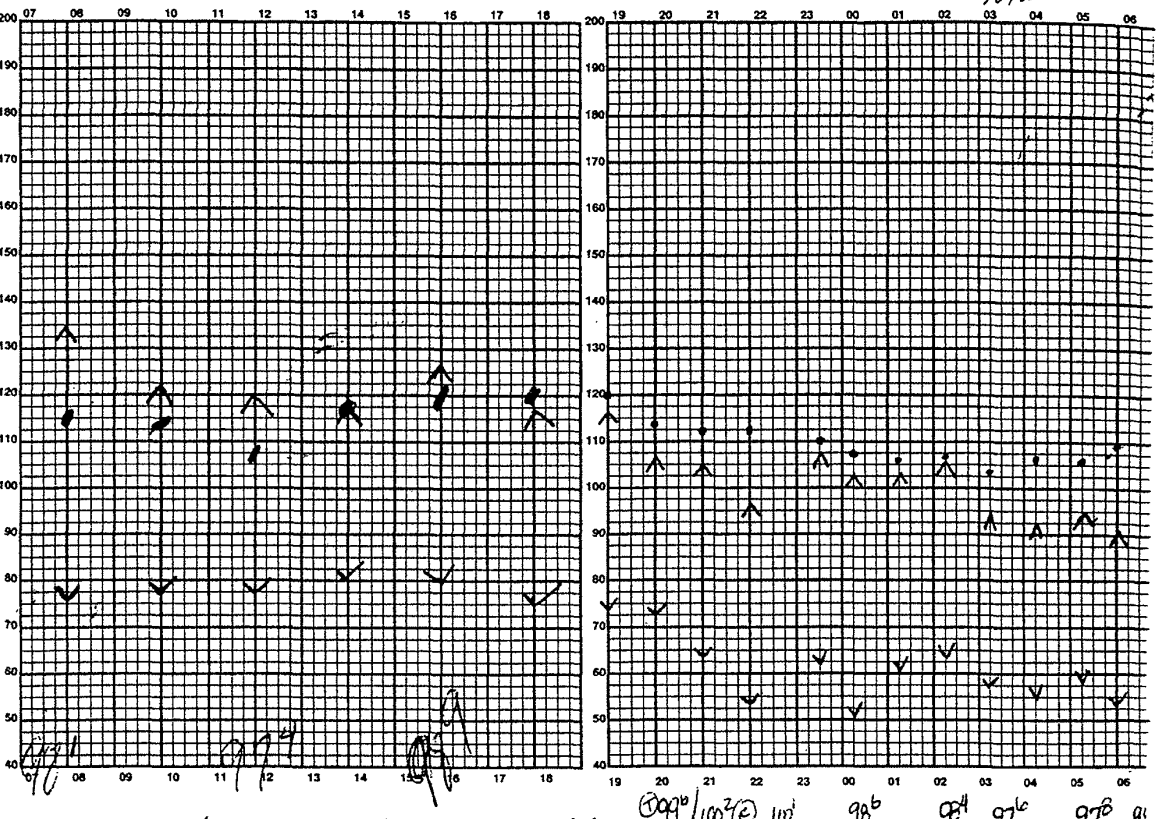
GLASGOW COMA SCALE

EYE OPENING	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensive Words	2
	None	1
MOTOR RESPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws (Pain)	4
	Flexion (Pain)	3
	Extension (Pain)	2
	None	1

PUPILS: cm 1 2 3 4 5 6 7 8

EXTREMITIES
STRENGTH (Grips)
3 - Strong
2 - Fair
1 - Weak
0 - Absent

PULSES
P = Palpable
D = Doppler
P1 - Weak
P2 - Fair
P3 - Strong
D1 - Monophasic
D2 - Biphasic
D3 - Triphasic



		07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
HEMODYNAMICS	Respirations	22		24		94.6		98		94.6		94.4		98.4		100.2 (E)	101	98.6		98.4		97.6		97.8	
	O2 Sat %	95%						93%						95	96		93	94		94		91	94		92
	CO/CI																								
	CVP/PCWP																								
	PAP																								
	SVR/PVR																								
NUERO	Eye Opening	1		1		1								1		1		1		1		1		1	
	Verbal Response	1		1		1								ETT		ETT		ETT		ETT		ETT		ETT	
	Motor Response	1		1		1								1		1		1		1		1		1	
	Total (≥ 7 indicates coma)	3		3		3								3		3		3		3		3		3	
	Pupils L	4SR												4SR		4SR		4SR		4SR		4SR		4SR	
	Pupils R	4SR												4SR		4SR		4SR		4SR		4SR		4SR	
	Extremities Arm L	0												0		0		0		0		0		0	
	Extremities Arm R	0												0		0		0		0		0		0	
	Extremities Leg L	0												0		0		0		0		0		0	
	Extremities Leg R	0												0		0		0		0		0		0	
PULSES	Time	0730												2030		2030		2350		0215		0345			
	Radial L	P3												P2		P2		P2		P2		P2			
	Radial R	P3												P2		P2		P2		P2		P2			
	Dorsalis Pedis L	P3												P2		P2		P2		P2		P2			
	Dorsalis Pedis R	P3												P2		P2		P2		P2		P2			
	Posterior Tibial L	P2												P1		P1		P1		P1		P1			
	Posterior Tibial R	P2												P1		P1		P1		P1		P1			

DATE: 7/21/01 ROOM# CCU8

UNITED REGIONAL HEALTH CARE SYSTEM
6-24-04 |N| 11TH
ARDWELL, JOHN W
ZCZERBA, ARTHUR J 9061 ADM 7/16/01
OB 9/01/61 039Y
0011324092 M
UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: ______ Current Wt.: ______

*Residuals are not included in the I & O unless discarded
‡ Indicate with 'V' the first void after d/c of Foley
§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

Hour	Soln Site: Diprivan (cc/dose)	Soln Site: PPA (cc/dose)	Soln Site: Vecuronium (cc/dose)	Soln Site: Albumin (cc/dose)	Soln Site: NS (cc/dose)	Soln Site: Heparin (cc/dose)	Soln Site (cc/dose)	Soln Site (cc/dose)	Soln Site (cc/dose)	Soln Site (cc/dose)	Tube Feeding	PO			Hourly / Sub Total	Resid*
07	10cc	15cc	10cc		20cc						[illegible]	NPO				
08																
09				100												
10																
11		100														
12																
13			7.5													
14			6.5													
15			20cc													
16																
17																
18																
TOTAL	121	1658	76	100	41											

TOTAL 12 INTAKE 1998

Hour	Urine ‡	NGT	Rectal tube			
07	Foley					
08						
09						
10	730					
11						
12	850					
13						
14						
15						
16						
17	700					
18			~~450~~			
TOTAL			450			

TOTAL 12 OUTPUT 2730

Hour	Diprivan drip	CAN	NS c IVPB								Tube Feeding	PO	NGT	RT	Hourly / Sub Total	Resid*
19												NPO				
20	25/43.8	100	20										60	120		
21	40/70.1															
22	45/78															
23																
00													60	120		
01																
02																
03																
04													60	120		
05	40/70															
06	45/78															
TOTAL	430	100	234										180	360		

TOTAL 12 INTAKE 2304

Hour	Urine ‡ (F)	GT	RT			
19						
20	175		100			
21						
22	250		250			
23						
00	500		450			
01						
02	150		300			
03						
04	150		300			
05						
06	450		850			
TOTAL	950	250	1300			

TOTAL 12 OUTPUT 2500 27-132

TOTAL 24° INTAKE 4402 | TOTAL 24° OUTPUT 5230 | 24° VARIANCE (-1053)

2

UNITED REGIONAL HEALTH CARE SYSTEM
36-24-04 |N| 11TH
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M
UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
				C	Renée Inselen RN
				JJ	J. Simmons RN

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment
1930	C	—	pt sedated c̄ Diprivan gtt					

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0740	am assessment	VSS. tracing ST 117. GCS 3. [illegible] abd distended BS hypoactive. Rectal tube draining dark stool. LS clear. peripheral edema noted. ETT taped @ 24 cm. OG tube to suction. no distress noted O2 sat 92% by vent. see flowsheet for complete details. — JJ
0830		retention enema completed meds given no Δs. tracing ST 116 — JJ
1000		no Δs. VSS. — JJ
1200		VSS. resp even and unlabored. tracing ST 119 — JJ
1300		Dr Chakerala here. orders received. Lasix dose
1400		norcuron weaned down. tolerating well. will continue to monitor. — JJ
1600		norcuron off. resp. notified ABGs drawn. VSS ST 118. — JJ
1830		no Δ in assessment. VSS tracing ST 119. — JJ
1930	PM Assessment	Pt in bed - restless. Resps ↑. ↑ed Diprivan to 25 ml° or 43.8 mcg. Bottle and tubing Δed. Pupils react - S ↓ R. Norcuron off. Sedated c̄ Diprivan but twitches and moves head away from stimulus. ∅ eye opening. ↑ extremities restrained c̄ soft wrist restraints - released during turning/repositioning. CMS intact. ↓ extremities restrained c̄ shackles (MSM). CMS intact. All pulses palp. VSS. O2 sat @ 95% via vent/ETT. Re-taped ETT c̄ assistance from Resp. tx. Moved to (L) side - remains 24 @ the lip. Suct. oral cavity. mod. amt thick yellow - blood tinged secretions. Oral care provided. ECG tracing ST. OGT to ↓ suct. placement verified c̄ air bolus. Lungs CTA. [illegible] hypoactive. Abdomen distended & firm. Rectal tube/foley cath draining to gravity s̄ difficulty. Cooling blanket on. Temp @ [illegible] IV [illegible] s̄ difficulty to (R) SC [illegible] 7b3

UNITED REGIONAL HEALTH CARE SYSTEM
36-24-04 |N| 11TH
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
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00011324092 M

Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time	0740	1930											
O2 via	ETT	vent											
L/M or FIO2	70	70											
CMV/SIMV Rate	20	20											
Vt	800	850											
CPAP / PEEP													
PSV													
PCV													
DS													

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	'04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn														(N) L		(I) R		(C) B		(C) L		(N) R		(N) L
CDB																								
TED Care																								
Bath/Shower																								
Mouth Care														(C)		(N)		(N)		(N)		(N)		
Foley Care																								
Trach Care																								
Oral/Naso/Trach/ETT Suctioning														oral	ETT	oral			ETT	oral		oral		
Sputum Amount (*Sm/Mod/Lg*)														mod	B	Sm			B	SM		Sm		
Consistency (*Th = Thick/T =*)														TH		TH				TH		TH		
Color														Yel Blood tinged		Sm/Sl				Sm/Sl		Sm/Sl		
HOB degree														30°										

NGT			IV INSERTION					IV SITE CARE			IABP/A-LINE DC'd		EQUIPMENT	
Tube Type			Site					Site			By		IV Pump	✓
Size			Gauge					Patent			Time		Feed Pump	
By			By					Drsg Applied			Bleeding		Oximeter	✓
Time			Time					By			Hematoma		Ventilator	✓
Placement 'd			Start Kit Used					Time			Site Clean		Temp Pace	
X-Ray			Injection Site					**DRAIN DC'd**			Pressure Drsg		SCD/K Ped	
To Suction		✓	# Attempts					Type			CMS adequate		Bard	
Clamped			**IV DC'd**					Site			**PA CATHETER DC'd**		IABP	
Feeding			Site					Drsg Applied			By		Camino	
D/C'd Time			Redness					By			Time		Geomatt	
FOLEY/STRAIGHT CATH			Bleeding					Time			Ectopy		Hypo/Hyper	✓
Size			Drainage					**CT DC'd**			**EXTUBATION**		Thermia Unit	
Sterile Tech. Used			Infiltration					Site			Hyperoxygenated			
By			Drsg Applied					By M.D.			Suctioned			
Time			By					Drsg Applied			Extubated by			
D/C'd Time			Time					Time			Time			

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		(R)
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.	AM	PM
*Requires Further Charting *Alternative		
	(R)	
Tube Wandering Fall *Measures		
Aggressive/Assaultive Time Applied		Cnx
Type: Wrist		x2
Vest		
Sheets to text. 4 pt.	✓	
✓ Done-Continues Needs Attended Q 2 hr		✓
per protocol:		✓
*Time Discontinued		1
Report given to next shift		(R)

27-13

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

PATIENT CARE RECORD - OBSERVATIONS

SPECIALTY CARE

Form # 8330/03 (REV. 12/99)

CODE STATUS: Full
ALLERGIES: NKDA

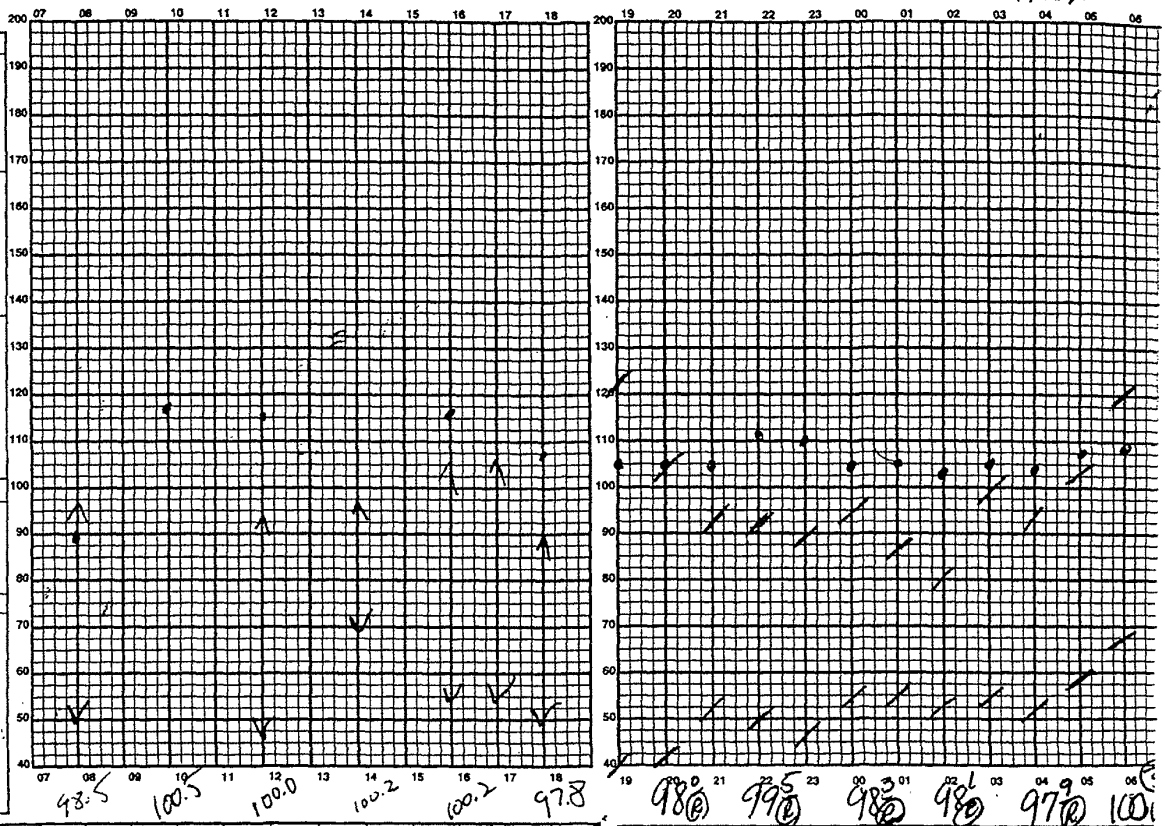
GLASGOW COMA SCALE

EYE OPENING	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensive Words	2
	None	1
MOTOR RESPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws (Pain)	4
	Flexion (Pain)	3
	Extension (Pain)	2
	None	1

PUPILS: cm 1 2 3 4 5 6 7 8

EXTREMITIES
STRENGTH (Grips)
3 - Strong
2 - Fair
1 - Weak
0 - Absent

PULSES
P = Palpable
D = Doppler
P1 - Weak
P2 - Fair
P3 - Strong
D1 - Monophasic
D2 - Biphasic
D3 - Triphasic



HEMODYNAMICS	Respirations	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
	Oz Sat %	90%	91%	93%	93%	90	92	95	93	96	95	93	97	95	94	95	95	94	97				
	CO/CI																						
	CVP/PCWP																						
	PAP																						
	SVR/PVR																						
NUERO	Eye Opening	1	1	1	1	1	1	1			1		1		1		1						
	Verbal Response	1	1	1	1	1	1	ET			ET		ET		ET		ET						
	Motor Response	1	1	1	1	1	1	1			1		1		1		1						
	Total (≥ 7 indicates coma)	3	3	3	3	3	3	2T			2T		2T		2T		2T						
	Pupils L	4SL	4SR	4SR	4SR	4SR	4SR	4S			4S		4S		4S		4S						
	Pupils R	4SR	4SR	4SR	4SR	4SR	4SR	4S			4S		4S		4S		4S						
	Extremities Arm L	0	0	0	0	0	0	0			0		0		0		0						
	Extremities Arm R	0	0	0	0	0	0	0			0		0		0		0						
	Extremities Leg L	0	0	0	0	0	0	0			0		0		0		0						
	Extremities Leg R	0	0	0	0	0	0	0			0		0		0		0						
PULSES	Time	0700	1000	1200	1400	1600	1800	1900			2200		0000		0200		0400						
	Radial L	P3	P3	P3	P3	P3	P3	P			P		P		P		P						
	Radial R	P3	P3	P3	P3	P3	P3	P			P		P		P		P						
	Dorsalis Pedis L	P3	P3	P3	P3	P3	P3	P			P		P		P		P						
	Dorsalis Pedis R	P3	P3	P3	P3	P3	P3	P			P		P		P		P						
	Posterior Tibial L	P2	P2	P2	P2	P2	P2	P			P		P		P		P						
	Posterior Tibial R	P3	P3	P3	P3	P3	P3	P			P		P		P		P						

CMS ✓

DATE: 7/22/01

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: _____ Current Wt.: _____

*Residuals are not included in the I & O unless discarded

‡ Indicate with 'V' the first void after d/c of Foley

§ Include liquid stool (cc's) in Output (B) Bag A'd (T) tubing A'd

INPUT & OUTPUT'S

	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site										
	PPI	Diprivan	NS	K-Rider																		
	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	cc DOSE	TUBE FEEDING	PO			HOURLY SUB TOTAL	RESID*		URINE ‡	NGT	Red Tube	
07	100cc	45cc	20cc															07				
08																		08	225			
09																		09				
10																		10	125			
11																		11				
12																		12	140			
13																		13				
14																		14	140			
15																		15				
16																		16	280			
17																		17				
18																		18	130		225	
TOTAL	266	540	403	20														TOTAL	960		275	
													TOTAL 12 INTAKE			2409			TOTAL 12 OUTPUT		1235	
	NPH	NS	DW 150									TUBE FEEDING	PO			HOURLY SUB TOTAL	RESID*		URINE ‡	NGT	Retail tube	
19	100	20	150															19	/			
20	(B)		150															20	150			
21																		21	150			
22																		22	/			
23																		23	115			
00													200 cmeds					00	105			
01																		01	-			
02																		02	115			
03																		03	-			
04			433															04	170			
05			(B)															05				
06													200 cmeds					06	195			
TOTAL	185	276	893										400					TOTAL	1000	50	950	137
													TOTAL 12 INTAKE			2853			TOTAL 12 OUTPUT		1000	
TOTAL 24° INTAKE													TOTAL 24° OUTPUT			3235			24° VARIANCE		+153	

36-24-04 |N| 11TH
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
0001324092
UNITED REGIONAL HEALTH CARE SYSTEM

Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time	0300	0900	2100
O2 via		ET	ET
L/M or FIO2	70	80	70
CMV/SIMV Rate	20	20	20
Vt	850	850	850
CPAP / PEEP			
PSV			
PCV			
DS			

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	'04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn				R		L		B		R					B			L			B			B
CDB																								
TED Care																								
Bath/Shower															✓									
Mouth Care					E						✓				✓									
Foley Care															✓									
Trach Care																								
Oral/Naso/Trach/ETT Suctioning															✓									
Sputum Amount (Sm/Mod/Lg)															Sm									
Consistency (Th = Thick/T =)															T									
Color															clear tinged									
HOB degree																								

NGT			IV INSERTION				IV SITE CARE			IABP/A-LINE DC'd		EQUIPMENT	
Tube Type			Site				Site			By		IV Pump	✓
Size			Gauge				Patent			Time		Feed Pump	
By			By				Drsg Applied			Bleeding		Oximeter	✓
Time			Time				By			Hematoma		Ventilator	✓
Placement 'd			Start Kit Used				Time			Site Clean		Temp Pace	
X-Ray			Injection Site				DRAIN DC'd			Pressure Drsg		SCD/K Ped	
To Suction			# Attempts				Type			CMS adequate		Bard	
Clamped			IV DC'd				Site			PA CATHETER DC'd		IABP	
Feeding			Site	LA	PA	LA	Drsg Applied			By		Camino	
D/C'd Time			Redness	Ø	Ø	Ø	By			Time		Geomatt	
FOLEY/STRAIGHT CATH			Bleeding	Ø	Ø	Ø	Time			Ectopy		Hypo/Hyper	
Size			Drainage	Ø	Ø	Ø	CT DC'd			EXTUBATION		Thermia Unit	✓
Sterile Tech. Used			Infiltration	Ø	Ø	Ø	Site			Hyperoxygenated			
By			Drsg Applied	[illegible]			By M.D.			Suctioned			
Time			By	[illegible]			Drsg Applied			Extubated by			
D/C'd Time			Time	2100	0700	2100	Time			Time			

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.		AM	PM
*Requires Further Charting	*Alternative		
Tube Wandering Fall	*Measures		✓
Aggressive/Assaultive	Time Applied		
	Type: Wrist		✓
	Vest		
	4 pt.		
✓ Done-Continues	Needs Attended Q 2 hr		✓
	per protocol:		✓
	*Time Discontinued		
Report given to next shift			✓

incarcerated in multiple shackled and/or restrain

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092

United Regional Health Care System

PATIENT CARE RECORD - OBSERVATIONS

SPECIALTY CARE

Form # 8330/03 (REV. 12/99)

CODE STATUS: Full
ALLERGIES: NKDA

GLASGOW COMA SCALE

- EYE OPENING: Spontaneous 4; To Voice 3; To Pain 2; None 1
- VERBAL RESPONSE: Oriented 5; Confused 4; Inappropriate Words 3; Incomprehensive Words 2; None 1
- MOTOR RESPONSE: Obeys Commands 6; Localizes Pain 5; Withdraws (Pain) 4; Flexion (Pain) 3; Extension (Pain) 2; None 1

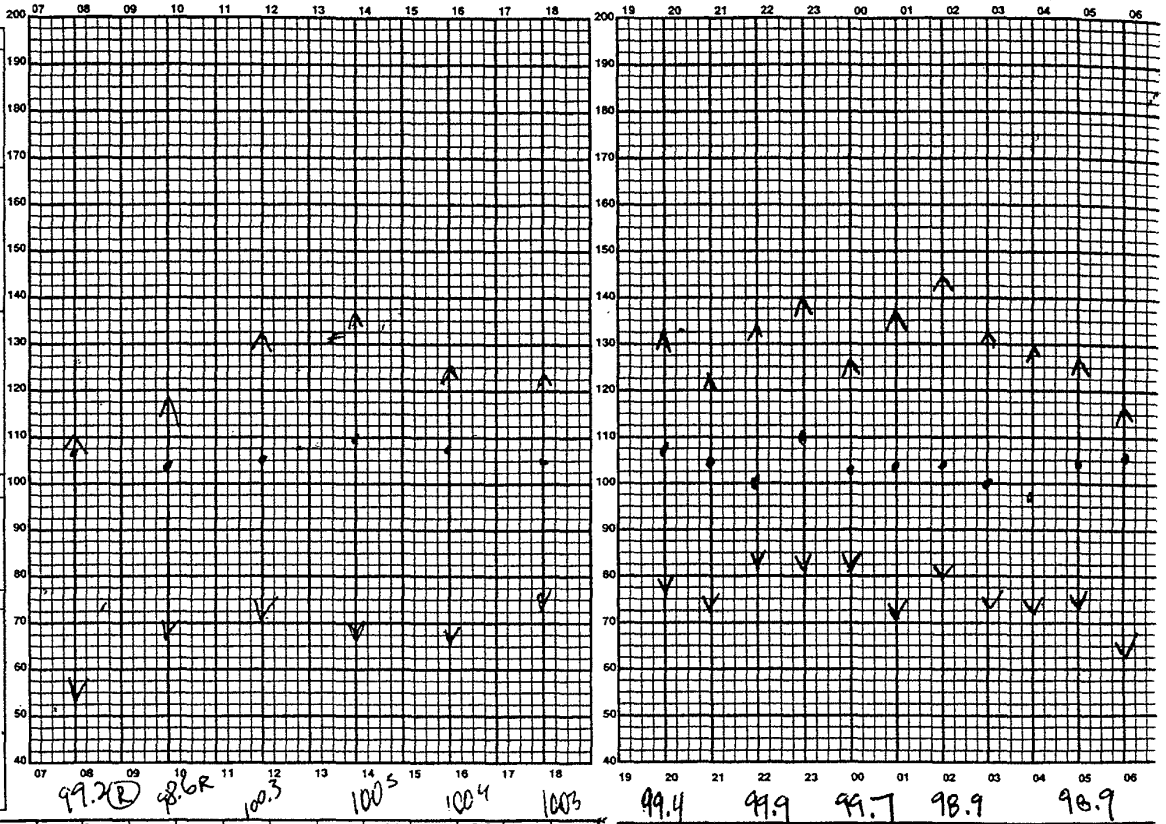
PUPILS

cm: 1 2 3 4 5 6 7 8

EXTREMITIES

STRENGTH (Grips)
3 - Strong
2 - Fair
1 - Weak
0 - Absent

PULSES
P = Palpable
D = Doppler
P1 - Weak
P2 - Fair
P3 - Strong
D1 - Monophasic
D2 - Biphasic
D3 - Triphasic



HEMODYNAMICS	Respirations	26	20	20	24	22	28	36	20	22	22	24	22	20	23	21	24
	O2 Sat %	91	93	95	93	91	97	90	90	93	95	90	97	94	96	97	96
	CO/CI																
	CVP/PCWP																
	PAP																
	SVR/PVR																
NUERO	Eye Opening	1	1	1	1	1	1										
	Verbal Response	1	1	1	1	1	1	ETT	ET	ET	ET	ETT	ETT	ETT	ETT	ET	ET
	Motor Response	1	1	1	1	1	1										
	Total (≥ 7 indicates coma)	3	3	3	3	3	3	3T	3T	3T	3T	3T	3T	3T	3T	3T	3T
	Pupils L	4SR	4SR	4SR	4SR	4SR		4L									
	Pupils R	4SR	4SR	4SR	4SR	4SR		4R									
	Extremities Arm L	0	0	0	0	0	0	~~0~~									
	Extremities Arm R	0	0	0	0	0	0	~~0~~									
	Extremities Leg L	0	0	0	0	0	0	~~0~~									
	Extremities Leg R	0	0	0	0	0	0	~~0~~									
PULSES	Time	0200	1000	1200				1430									
	Radial L	P3	P3	P3	P3	P3	P3	P3									
	Radial R	P3	P3	P3	P3	P3	P3	P3									
	Dorsalis Pedis L	P3	P3	P3	P3	P3	P2	P2									
	Dorsalis Pedis R	P3	P3	P3	P3	P3	P2	P2									
	Posterior Tibial L	P2	P2	P2	P2	P2	P2	P2									
	Posterior Tibial R	P2	P2	P2	P2	P2	P2	P2									

27-138

DATE: 7/22/01 ROOM: CC 18

UNITED REGIONAL HEALTH CARE SYSTEM
36-24-04 |N| 11TH
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: ______ Current Wt.: ______

*Residuals are not included in the I & O unless discarded
‡ Indicate with 'V' the first void after d/c of Foley
§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

Hour	Soln Site CPN (cc/DOSE)	Soln Site NS (cc/DOSE)	Soln Site Diprivan (cc/DOSE)	Soln Site KCL (cc/DOSE)	Soln Site NS 40 KCL (cc/DOSE)	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Tube Feeding	PO	NG		Hourly Sub Total	Resid*	Hour	Urine ‡	NGT	RT			
07	100cc	20cc	10cc/5mg															07						
08																		08	150					
09																		09	110					
10																		10	125					
11																		11	200					
12																		12	220		475			
13																		13	300/340					
14														60				14	100					
15																		15						
16		(B)	(B)(T)															16	350					
17														20				17	100					
18														60				18	75		175			
TOTAL	1204	361	500	198										240				TOTAL	1970		650			

TOTAL 12 INTAKE 2501 | TOTAL 12 OUTPUT 2620

Hour	IV	IV	cc/DOSE	IV (crossed out)	IV							Tube Feeding	PO			Hourly Sub Total	Resid*	Hour	Urine ‡	NGT	RT	NG		
19	100	20	42/7?															19						
20		DC'D																20	175					
21				50	50													21	100					
22																		22	100					
23																		23	120					
00																		00						
01																		01	300					
02																		02	110					
03																		03	125					
04																		04						
05																		05	200					
06																		06	150					
TOTAL	1220	20	510		539													TOTAL	1380		200	(500)	2139	

TOTAL 12 INTAKE 2289 | TOTAL 12 OUTPUT 2080

TOTAL 24° INTAKE 4796 | TOTAL 24° OUTPUT 4700 | 24° VARIANCE 96

UNITED HE[illegible] [illegible]AL HEALTH CARE SYSTEM
36-24-04 [N] 11TH
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

United Regional Health Care System

Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
TG	V. Grimes RN			JJ	T. Gonzalez RN
				CR	C. Russell RN

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment
1930	JJ	0	Pt UNRESPONSIVE					

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0800		Pt sedated c̄ no response to pain corneal reflex absent, babinski absent pupils @ 4mm and very sluggish to react to light. Pt on vent see flow sheet for settings + I&O sheet for drips and flow sheet for full assessment. CPN, Diprivan & NS to Ⓡ SC catheter site. Rectal tube in place, Foley draining dark tea colored urine rectal probe for temp and cooling blanket on set to 37°C. Pt c̄ soft [illegible] restraint and ankle shackles per prison protocol. 2+ generalized edema. Lungs upper CTA c̄ ↓ BS RLL. OGT clamped at [illegible]. Eyes, sclera jaundiced. Will cont to monitor. C Russell RN
0915		Dr Patel here to see patient - Orders written. Pt [illegible] red bloody [illegible] secretions noted. C Russell RN
1100		Pt turned to Ⓛ side respiratory effort ↑ to 35-40. Dr Clark [illegible] notified and in room. Morphine 3mg ordered and given. c̄ desired effects. Dr Clark [illegible] notified of improvement in resp. effort
1130		Resident in room - [illegible] [illegible] resp. effort related to [illegible] activity. EEG ordered. No other changes in assessment. C Russell RN
1315		Pt resting c̄ sedation. ∅ changes from above assessment. Cooling blanket on at this time. Pt placed on back. Tech here for EEG. Sitters at bedside. V. Grimes RN
1400		Meds given via NG c̄ then clamped. Residents @ bedside Questions answered. ∅ changes c̄ pt. EEG done. TG
1525		ETT retaped. Blood drawn & sent to lab @ 1500. TG
1600		Labs [illegible] [illegible] [illegible] per dr. request. ∅ orders received. V. Grimes RN 27 c̄ [illegible]
		Slight [illegible] noted to [illegible] upper extremities [illegible] Ⓛ. Resident

UNITED REGIONAL HEALTH CARE SYSTEM

11TH

36-24-04 |N|

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Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time	0800	1000	1205	1430	1935	1940	1943	2340				
O2 via				7200								
L/M or FIO2	70	60	50	50	60	70	65	40				
CMV/SIMV Rate	20	8	20	20								
Vt	850		850	850								
CPAP / PEEP			0				25					
PSV												
PCV												
DS												

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn		VK		VC			B		R		B			JJ				J						
CDB																								
TED Care																								
Bath/Shower																								
Mouth Care					—				✓															
Foley Care																								
Trach Care																								
Oral/Naso/Trach/ETT/Suctioning									OE					JJ										
Sputum Amount (Sm/Mod/Lg)									Mod					Sm										
Consistency (Th = Thick/T =)									Th					TH										
Color									Red Tan					Blood										
HOB degree																								

NGT			IV INSERTION					IV SITE CARE			IABP/A-LINE DC'd		EQUIPMENT	
Tube Type			Site					Site			By		IV Pump	✓
Size			Gauge					Patent			Time		Feed Pump	
By			By					Drsg Applied			Bleeding		Oximeter	✓
Time			Time					By			Hematoma		Ventilator	✓
Placement 'd			Start Kit Used					Time			Site Clean		Temp Pace	
X-Ray			Injection Site					DRAIN DC'd			Pressure Drsg		SCD/K Ped	
To Suction			# Attempts					Type			CMS adequate		Bard	
Clamped			IV DC'd					Site			PA CATHETER DC'd		IABP	
Feeding			Site					Drsg Applied			By		Camino	
D/C'd Time			Redness					By			Time		Geomatt	
FOLEY/STRAIGHT CATH			Bleeding					Time			Ectopy		Hypo/Hyper	
Size			Drainage					CT DC'd			EXTUBATION		Thermia Unit	✓
Sterile Tech. Used			Infiltration					Site			Hyperoxygenated			
By			Drsg Applied					By M.D.			Suctioned			
Time			By					Drsg Applied			Extubated by			
D/C'd Time			Time					Time			Time			

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.		AM	PM
*Requires Further Charting	*Alternative		
Tube Wandering Fall	*Measures		✓
Aggressive/Assaultive	Time Applied		
	Type: Wrist		✓
	Vest		
	4 pt.		
✓ Done-Continues	Needs Attended Q 2 hr		✓
	per protocol:		✓
	*Time Discontinued		
Report given to next shift			✓

9430 PT HEAVILY SEDATED, BUT JERKY MOVEMENTS & FACIAL GRIMACING INTERMITTENT. PUPILS EQUAL, REACTIVE TO LIGHT. RESPIRATIONS ROMAN—

UNITED REGIONAL HEALTH CARE SYSTEM

11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

PATIENT CARE RECORD - OBSERVATIONS

SPECIALTY CARE

Form # 8330/03 (REV. 12/99)

CODE STATUS _____
ALLERGIES: _____

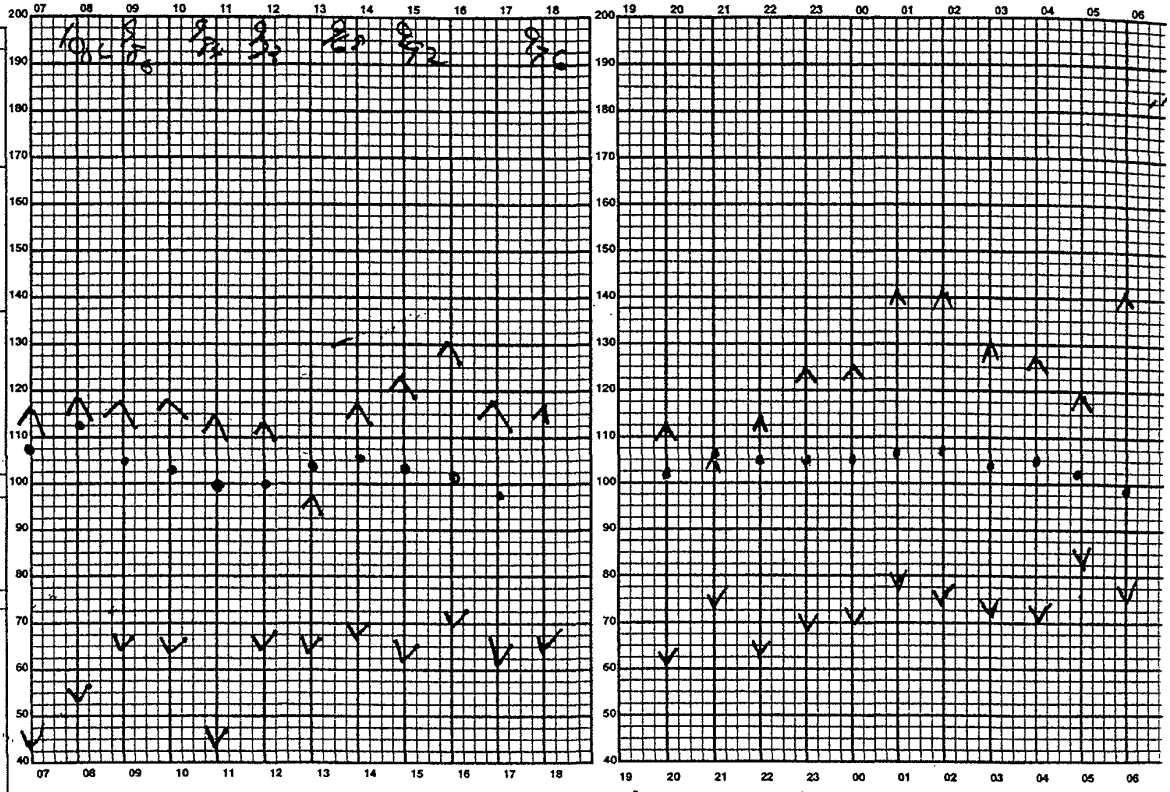
GLASGOW COMA SCALE

EYE OPENING	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate Words	3
	Incomprehensive Words	2
	None	1
MOTOR RESPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws (Pain)	4
	Flexion (Pain)	3
	Extension (Pain)	2
	None	1

PUPILS: cm 1 2 3 4 5 6 7 8

EXTREMITIES
STRENGTH (Grips)
3 - Strong
2 - Fair
1 - Weak
0 - Absent

PULSES
P = Palpable
D = Doppler
P1 - Weak
P2 - Fair
P3 - Strong
D1 - Monophasic
D2 - Biphasic
D3 - Triphasic



99.5 99.7 99.5 99.3 100.2 98.7 99.5

HEMODYNAMICS	Respirations	23	20	20	24	22	28	24	26	26	28	20	20
	O2 Sat %	99	94	91	90	94	94	92	93	94	86	95	96
	CO/CI												
	CVP/PCWP												
	PAP												
	SVR/PVR												
NUERO	Eye Opening	1					1				1		
	Verbal Response	1					1				1		
	Motor Response	1					1				1		
	Total (≥ 7 indicates coma)	3					3				3		
	Pupils L	3R 4					3R 4				3R 4		
	Pupils R	3R 4					3R 4				3R 4		
	Extremities Arm L	0					0				0		
	Extremities Arm R	0					0				0		
	Extremities Leg L	0					0				0		
	Extremities Leg R	0					0				0		
PULSES	Time												
	Radial L	P3											
	Radial R	P3											
	Dorsalis Pedis L	P2											
	Dorsalis Pedis R	P2											
	Posterior Tibial L	P2											
	Posterior Tibial R	P2											

HEMODYNAMICS	Respirations	20	20	20	20	20	20	20	20	20			20
	O2 Sat %	97	95	96	94	96	94	94	92	94			96
	CO/CI												
	CVP/PCWP												
	PAP												
	SVR/PVR												
NUERO	Eye Opening	1		1		1	1	1		1			1
	Verbal Response	ETT		ETT		ETT	ETT			ETT			ETT
	Motor Response	1		1		1	1			1			1
	Total (≥ 7 indicates coma)	3T		3T		3T	3T			3T			3T
	Pupils L	4R											
	Pupils R	4R											
	Extremities Arm L	0											
	Extremities Arm R	0											
	Extremities Leg L	0											
	Extremities Leg R	0											
PULSES	Time												
	Radial L	P3											
	Radial R	P3											
	Dorsalis Pedis L	P2											
	Dorsalis Pedis R	P2											
	Posterior Tibial L	P2											
	Posterior Tibial R	P2											

DATE: 7/24/01 ROOM: STRK

UNITED REGIONAL HEALTH CARE SYSTEM
11TH
36-24-04 IN
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092

United Regional Health Care System

Form # 8330/03(REV. 12/99)

Previous Wt.: ______ Current Wt.: ______

*Residuals are not included in the I & O unless discarded
‡ Indicate with 'V' the first void after d/c of Foley
§ Include liquid stool (cc's) in Output

INPUT & OUTPUT'S

Hour	Diprivan (cc/dose)	NS 40K (cc/dose)	TPN (cc/dose)	Norcuron 20/100 ml (cc/dose)	NS (cc/dose)	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Tube Feeding	PO	Hourly / Sub Total	Resid*
07	52/74	50	100											
08														
09														
10														
11														
12												120		
13														
14														
15														
16														
17														
18	33											120		
TOTAL	485	636	1172	20								240		

TOTAL 12 INTAKE 2553

Hour	Urine ‡	NGT	Rectal				
07	110						
08	110						
09	110						
10	100						
11							
12	150						
13	75						
14	75						
15	75 / 250	150					
16	250 / 350	200					
17	420	110 (2100)					
18	260						
TOTAL	1450	300	380				

TOTAL 12 OUTPUT 2050

Hour	Diprivan (cc/dose)	NS 40K (cc/dose)	TPN (cc/dose)	Norcuron (cc/dose)	NS (cc/dose)	Soln Site	Soln Site	Soln Site	Soln Site	Soln Site	Tube Feeding	PO	Hourly / Sub Total	Resid*
	14/dose	10	10	16/dose	10									
19	35/61	off	100	15/3	10									
20														
21														
22														
23	30/53													
00														
01														
02														
03														
04														
05														
06														
TOTAL	[illegible]		1172	172	202									

TOTAL 12 INTAKE 1902

Hour	Urine ‡	NGT	Rectum	NG			
19							
20	220						
21	150						
22	100						
23	100						
00	125						
01							
02	175						
03	115						
04	75						
05							
06	165						
TOTAL	1225		600	550			

TOTAL 12 OUTPUT 2375 (1493)

TOTAL 24° INTAKE 4455 **TOTAL 24° OUTPUT** 4425 **24° VARIANCE** 30

UNITED REGIONAL HEALTH CARE SYSTEM 11TH
36-24-04 |N|
CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092
UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
		mom	[illegible] RN	TJ	T. Johnson RN

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment
1915	TJ	Pt	SEDATED +	PARALYZED — TJ				

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0715		Pt received for care. Physical Assessment completed
		See flowsheet. Pt is sedated and is intubated.
		Pt noted to be using ~~[illegible]~~ own abdominal muscles for breathing
		against ventilator. Norcuron 5 mg IV given. Breath sounds
		have diminished breath sounds and are clear. Cooling blanket
		is in place. IV solutions & rates verified. Foley & rectal
		tube are in place. NG tube is in place to suction. Cardiac
		monitor shows sinus tachycardia. Guards x3 are at bedside
		pt has bilateral ankle shackles in place, soft restraints are in
		place to ↑ extremities. — mom
0800		Pt repositioned & mouth care completed — mom
0900		Dr Memkodi here no orders & signed off case — mom
1000		Pt suctioned for thick yellow c old bld clots. Mouth
		care completed & pt repositioned — mom
1200		Status is unchanged from initial assessment.
		Pt repositioned. — mm
1400		Pt status is unchanged. Pt is repositioned. — mom
1500		O_2 sat 85-89% pt suctioned & jetted c moderate return
		of yellow bloody secretions. Resp therapy paged due to sat
		sat ↑ to 95% then fell back down to 88% — mom
1600		VS & open graphics. Pt repositioned. — mom
1620		Resp rate ↑ to 26 MS 2 mg IV given — mom
1645		Resp rate 26-30. Pt appears agitated / fighting ventilator —
		Norcuron 5 mg IV given. Dr Chikhunde paged — mom
~~1700~~	1710	Dr Chikhunde [illegible] call orders received — mom
1730		Norcuron [illegible] as per order — mm
1800		Pt is resting quietly. I/O calculated — mm

UNITED REGIONAL HEALTH CARE SYSTEM

11TH

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SZCZERBA, ARTHUR J 039Y M
DOB 9/01/61
00011324092

UNITED REGIONAL HEALTH CARE SYSTEM

Form # 8330/03 (REV. 12/99)

NURSING INTERVENTIONS

Time	1915																						
O2 via	T200																						
L/M or FIO2	70																						
CMV/SIMV Rate	19																						
Vt	850																						
CPAP / PEEP																							
PSV																							
PCV																							
DS																							

NURSING INTERVENTIONS

HOUR	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
Ambulation																								
Up to Chair																								
Dangle																								
Turn														JJ		JJ		JJ		J		D		
CDB																								
TED Care																								
Bath/Shower																								
Mouth Care					✓													JJ						
Foley Care																								
Trach Care																								
Oral/Naso/Trach/ETT Suctioning																								
Sputum Amount (Sm/Mod/Lg)																								
Consistency (Th = Thick/T =)																								
Color																								
HOB degree																								

NGT			IV INSERTION			IV SITE CARE			IABP/A-LINE DC'd		EQUIPMENT	
Tube Type			Site			Site			By		IV Pump	
Size			Gauge			Patent			Time		Feed Pump	
By			By			Drsg Applied			Bleeding		Oximeter	
Time			Time			By			Hematoma		Ventilator	
Placement 'd			Start Kit Used			Time			Site Clean		Temp Pace	
X-Ray			Injection Site*			DRAIN DC'd			Pressure Drsg		SCD/K Ped	
To Suction			# Attempts			Type			CMS adequate		Bard	
Clamped			IV DC'd			Site			PA CATHETER DC'd		IABP	
Feeding			Site			Drsg Applied			By		Camino	
D/C'd Time			Redness			By			Time		Geomatt	
FOLEY/STRAIGHT CATH			Bleeding			Time			Ectopy		Hypo/Hyper	
Size			Drainage			CT DC'd			EXTUBATION		Thermia Unit	
Sterile Tech. Used			Infiltration			Site			Hyperoxygenated			
By			Drsg Applied			By M.D.			Suctioned			
Time			By			Drsg Applied			Extubated by			
D/C'd Time			Time			Time			Time			

FALL PRECAUTIONS	Initials 7 a-p	Initials 7 p-a
NURSING DIAGNOSIS: POTENTIAL FOR INJURY R/T HIGH RISK FOR FALL		
DESIRED OUTCOME: NO FALLS OR INJURY DURING HOSPITAL STAY		
Stress fall prevention information with Patient and family once per day and PRN		
Check for Yellow bracelet on Patient once per day		
Check for Yellow symbol on chart and kardex once per day		
Check door open & lighting sufficient to visualize Patient q 4 hours and PRN		
Confirm all side rails up, bed in low position q 4 hours and PRN		
Confirm presence of call light within reach and reinforce use of q 4		
Ensure Patient has slippers with rubber soles for out-of-bed activities		
Provide mandatory assistance to BSC or BR prn. Remain with Patient while up to BSC or BR		
Provide mandatory assistance with ambulation		
Apply reminder belt or posey vest when up to chair as indicated		
Apply bed sensor per nurse discretion. Check alarms "on" at all times when Patient in bed		
Offer toileting at HS and PRN		

RESTRAINT/M.P.D.		AM	PM
*Requires Further Charting	*Alternative		
Tube Wandering Fall	*Measures		✓
Aggressive/Assaultive	Time Applied		
	Type: Wrist		✓
	Vest		
	4 pt.		
✓ Done-Continues	Needs Attended Q 2 hr		✓
	per protocol:		
	*Time Discontinued		
Report given to next shift			

1915 PT IN CUSTODY + SOFT WRIST RESTRAINTS USED INSTEAD OF SHACKLES
7/16/01

See Admission Assessment database for initial admitting assessment

ASSESSMENT	AM	PM
MENTAL		
Alert		
Cooperative/Uncooperative		
Anxious/Restless/Agitated		
Speech Clear/Slurred		
PULMONARY		
Breath Sounds: Clear R/L		
PM: BASES Crackles R/L		
Wheezes R/L		
Rhonchi R/L		
Diminished R/L		
Absent R/L		
Resp. Effort: Regular/Irregular		
Unlabored/Labored		
Accessory Muscle Use	NKS	NKS
Symmetrical Chest Expansion		
Denies/Admits SOB or Dyspnea		
Cough: Productive/Nonproductive		
Color		
Tracheostomy		
Cuff up/down		
Tube secured in place		
Ambu at bedside		
ET tube: oral/nasal		
# cm at teeth/lip	24	24
size	8.0	8.0
CHEST TUBES		
CT # 1 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 2 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 3 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 4 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		

ASSESSMENT	AM	PM
CARDIAC		
Apical Pulse Regular /Irregular	✓	✓
Capillary Refill: < 2 sec/>2 sec	✓	✓
Neck Veins: Flat/Distended	✓	✓
EKG Rhythm	ST	ST
Lead	II	II
EKG Hi/Lo Alarms On at:	150	150
Pacer: Temporary/Permanent		
Insertion Depth (cm)		
Transvenous/External		
Epicardial Wires		
Pulse Generator On/Off		
Rate		
MA		
Demand/Asynchronous		
HEMODYNAMICS		
Transducers: Leveled with RA		
Zeroed & Calibrated		
1000 U. Heparin		
500 CC. NS Flush		
A - Line Site:		
Proper Wave Form		
MAP HI/LO Alarms On at		
Drsg dry & Intact		
PA Catheter Site:		
Insertion Depth (cm)		
Proper Waveform		
Drsg Dry & Intact		
CVP Catheter Site:		
Proper Waveform		
Drsg Dry & Intact		
IABP Site:		
Ratio I:		
Proper Augmentation		
Alarm On		
Drsg Dry & Intact		
SKIN		
Intact/Break in Skin Surface*	✓	✓
Warm Cool	✓	✓
Dry/Clammy/Diaphoretic	✓	✓
Pink/Pale (✓ nailbeds/mucous membranes)	✓	✓
Cyanotic/Flushed/Jaundiced		✓
Edema - Site	Lem	gen +2
+1 +2 +3 P=Pitting		
GI - GU		
Urine Color	Amb	Amb
Clear/Cloudy/Bloody	✓	✓
Voids/Foley/CBI	✓	✓
Abdomen: Soft/Firm	✓	✓
Flat/Distended	✓	✓
Nontender/Tender	✓	✓
Bowel Sounds: Present/Absent	✓	✓
Hypoactive/Hyperactive	✓	✓
Expels Flatus		
NGT/PEG (Placement verified)	✓	✓
suction/clamped/feeding	✓	✓
Urostomy/Ileostomy/Colostomy		
Stoma Pink/Other		

ASSESSMENT	AM	PM
SURGICAL WOUNDS		
Incision #1 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
Incision #2 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
DRAINS		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
IV ACCESSES		
IV Access: Site RT T.L.C	✓	✓
Patent	✓	✓
IV Access: Site		
Patent		
IV Access: Site		
Patent		
SAFETY		
Bed in Low Position	✓	✓
Call Light in Reach	✓	✓
Side Rails Up: Upper/Full	✓	✓
POTENTIAL FOR VIOLENCE		No
ASSESSORS		
Assessors Initials	AR	mon
	PA	JY

RN SIGNATURE J. Gonzales RN 1915

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W.
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

97-146

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

(1915) Pt Assessed + Care Assumed. Pt Sedated + Paralyzed. Pupils Equal + Sluggish To React. Orally Intubated + To Vent c̄ 8.0 ETT 24 @ Lip. Lungs c̄ Coarse Rhonchi that persist Post Suction c̄ Sm Amount Thick, Bloody Secretions. Crackles Auscultated To Bases Bilat. OG Tube in place + Clamped. Placement Verified by Auscultation of Air Bolus. Abd Firm, Distended. BS Heard RL Quad. Foley c̄ Dark Amber Urine in Bag. Rectal Tube in place c̄ liquid, green stool in Bag. Pt Has generalized Edema c̄ ↑ Edema To Hands + Ankles. (R) SC [illegible] in place. Please See IV Flow Sheet + PM VList. For other Data. ST on Monitor, Ø Ectopy observed —— JJ ——

(2115) No Δ in Cond. ETT Suctioned c̄ Same Results As Above. (2200) Re-Positioned. (0000) Re-Positioned. Meds given. Ø Δ in Pulm. Assess. Remains Paralyzed + Sedated. GCS—3T —— JJ

(0200) ETT Suctioned, Sm Amount Thick Brown Secretions Returned. Re-Positioned. (0400) Pt Bathed + Linens Δ'd. ETT Re-Taped. No Δ in Assess —— JJ (0600) No Δ in Assess or Neuro Δ's —— JJ. (0645) Report To 7A-7P Shift —— JJ

27-147

☐ SEE CONTINUED NURSES' SUMMAR

See Admission Assessment database for initial admitting assessment

ASSESSMENT	AM	PM
MENTAL		
Alert	Sedated	
Cooperative/Uncooperative		
Anxious/Restless/Agitated		
Speech Clear/Slurred		
PULMONARY		
Breath Sounds: Clear R/L	✓	✓
Crackles R/L		
Wheezes R/L		
Rhonchi R/L		✓
Diminished R/L	✓	
Absent R/L		
Resp. Effort: Regular/Irregular	✓	✓
Unlabored/Labored	✓	✓
Accessory Muscle Use		
Symmetrical Chest Expansion	✓	✓
Denies/Admits SOB or Dyspnea		
Cough: Productive/Nonproductive		
Color		
Tracheostomy		
Cuff up/down	✓	✓
Tube secured in place	✓	✓
Ambu at bedside	✓	✓
ET tube: oral/nasal	✓	✓
# cm at teeth/lip	24	24
size	8D	8.D
CHEST TUBES		
CT # 1 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 2 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 3 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 4 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		

ASSESSMENT	AM	PM
CARDIAC		
Apical Pulse Regular /Irregular	✓	✓
Capillary Refill: < 2 sec/>2 sec	✓	✓
Neck Veins: Flat/Distended	✓	✓
EKG Rhythm	ST	ST
Lead	II	II
EKG Hi/Lo Alarms On at:	100/50	100/50
Pacer: Temporary/Permanent		
Insertion Depth (cm)		
Transvenous/External		
Epicardial Wires		
Pulse Generator On/Off		
Rate		
MA		
Demand/Asynchronous		
Transducers		
Leveled with RA		
Zeroed & Calibrated		
1000 U. Heparin		
500 CC. NS Flush		
HEMODYNAMICS		
A - Line Site:		
Proper Wave Form		
MAP HI/LO Alarms On at		
Drsg dry & Intact		
PA Catheter Site:		
Insertion Depth (cm)		
Proper Waveform		
Drsg Dry & Intact		
CVP Catheter Site:		
Proper Waveform		
Drsg Dry & Intact		
IABP Site:		
Ratio I:		
Proper Augmentation		
Alarm On		
Drsg Dry & Intact		
SKIN		
Intact/Break in Skin Surface*	✓	✓
Warm Cool	✓	✓
Dry/Clammy/Diaphoretic	✓	✓
Pink/Pale (✓ nailbeds/mucous membranes)	✓	✓
Cyanotic/Flushed/Jaundiced		✓
Edema - Site	General 2+	2+
+1 +2 +3 P=Pitting		
GI - GU		
Urine Color	dark tea color	dark
Clear/Cloudy/Bloody		
Voids/Foley/CBI	✓	✓
Abdomen: Soft/Firm	✓	✓
Flat/Distended		
Nontender/Tender	✓	✓
Bowel Sounds: Present/Absent	✓	✓
Hypoactive/Hyperactive		
Expels Flatus	RD	
NGT/PEG (Placement verified)	✓	✓
suction/clamped/feeding	✓	✓
Urostomy/Ileostomy/Colostomy		
Stoma Pink/Other		

ASSESSMENT	AM	PM
SURGICAL INCISIONS		
Incision #1 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
Incision #2 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
DRAINS		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
IV ACCESSES		
IV Access: Site	RSC	
Patent	✓	
IV Access: Site		
Patent		
IV Access: Site		
Patent		
SAFETY		
Bed in Low Position	✓	
Call Light in Reach	✓	
Side Rails Up: Upper/Full	✓	
POTENTIAL FOR VIOLENCE	NO	NO
ASSESSORS		
Assessors Initials	AR	
	PA	

cRussell RN

RN SIGNATURE

T. Johnson RN

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 IN 11TH

CARDWELL, JOHN W

SZCZERBA, ARTHUR J 9081 ADM 7/16/01

DOB 9/01/61 039Y M

00011324092

UNITED REGIONAL HEALTH CARE SYSTEM

36-24-04 |N| 11TH

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

UNITED REGIONAL HEALTH CARE SYSTEM

United Regional Health Care System

Form # 8330/03 (REV. 12/99)

SIGNATURE KEY

Initials	Name, Title	Initials	Name, Title	Initials	Name, Title
LS	L Steen RN				
				CR	C Russell RN

PRN MEDICATION ASSESSMENT

(Pain Scale: 0=no pain & 10= maximum pain)

☐ **Pt. has PCA or Epidural: See Pain Management 24° Flow Sheet for Documentation R/T Pain Management**

INITIAL ASSESSMENT					EVALUATION OF INTERVENTION			
Time	Initials	Pain Level	Problem/Focus	Intervention	Time	Initials	Pain Level	Assessment
1900	LS	–		sedated				

NARRATIVE NOTES

Nursing Dx Must Be Addressed In Patient Care Record Until Resolved

Time		Intervention & Evaluation
0800		Pt sedated on Vent. See Flow sheet for vent setting, full
		assessment + I&O sheet for IV infusions. Pt unresponsive to pain.
		pupils reactive + sluggish to 4 mm, Sclera yellow, generalized edema
		of 2+. +BS. OGT clamped. Rectal tube to gravity. All lobes diminished
		+ [illegible] ā GBS. Telemetry reads SR ā HR 90. Temp 98.5 per rectal
		probe. Pt ā soft wrist restraints + shackles to LE C Russell RN
1000		Dr Chakravarty here to see pt. Order written. No changes in pt
		C Russell RN
1030		↓ Dopamine to 70 mcg/kg/min = 40 cc/hr. lungs ↓ in RLL. Pt turned
		to (R) side. C Russell RN
1445		Respiratory effort ↑ and setting of High frequency alarms, [illegible]
		Dr Chakravarty gave order for Nimbex. C Russell RN
1500		Respiratory effort [illegible] and regulated by vent. No other
		changes in assessment. C Russell RN
1730		Rectal tube putting out Ø. Deflated bulb and repositioned.
		Rectal tube [illegible] ā 30cc. liquid bowel draining per
		gravity. C Russell RN
1800		Care report to [illegible] RN. Pt assessment remains unchanged.
		C Russell RN
1900		Report from am shift, sedated + paralyzed, VSS
		normothermic @ present, see attached sheet for
		detailed assessment — LS (2100) Bathed,
		shaved, VSS, collected sputum for C+S and
		Gram stain, hypoactive cough reflux, only
		slight resistance observed when opening
		mouth [illegible] drainage from
		rectal tube, slight oozing around tube

3

DATE: 7/21/01 ROOM# CCU

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

informed. To (1700) ¢ changes. VSS. To (1815) ¢ changes. VSS. Cooling blanket still on at this time. Abd distended & generalized edema still noted. To (1930) PT Assessed + Care Assumed. PT Sedated on Propofol + To Vent (See Settings). + Response To Pain Stimuli, + gag Reflex. pupils Equal / Sluggish To React. Resp ↑ 30's, Irregular. Jerky Movements To ↑ + Torso. Dr Chakinala Here + updated on Δ's. Orders Received For Nebulizer. Lungs Clear c Abd. Muscles in use For Resp. ETT Suctioned c Sm, Thick Bloody Secretions. O2 Sat Dropped into low 80's. Ambu Bag at 100% Fio2 c Immediate Return of Sat into 90's. ↓ Fio2 To 60% c ↓ Result, Final Titration of Fio2 To 85% To Maintain O2 Sat in low 90s. Abd Distented c Hypotonic Bs. OG Tube in place. Placement Verified by Auscultation of Air Bolus. PPP. Foley in place draining Amber Colored Urine. Rectal Tube in place c green liquid Stool in Bag. Please See IV Flow Sheet + Pin √ List For other Data. SR on Monitor c Ectopy Observed — JG. (1940) PT Breathing Pattern Stated, in Sync c 7200 Vent. (2200) Some Jerky Movements Observed To ↑ Torso. Dr Lim Here Earlier this Pm + Informed of Movements (Seizure?), Resp Status + VS. + Orders Received. (2230) Resp ↑ 30's, Jerky Movements To Shoulders, Arms. High Pressure on Vent. Sm Noc Given. SR on Monitor — JG. (2240) + Movement, No Δ in Assess. (000) PT O2 Sat Holding in ↓ 90's c Fio2 85%, Unable To Wean 2° To ↓ O2 Sat c ↓ in Fio2. PT Having Intx. Jerky, Seizure like Movements To ↑ Torso. Some Movements As Before. No Neuro Status Δ's Observed. (0200) No Δ in Assess. or Neuro Δ's. — JG. (0340) ↑ Jerky Movements. guppy like Breathing on Vent, Out of Sync. Noc Given. Sm Sup given. — JG. (0360) + Movement Post Intx. No Δ ↓ in Assess. (0430) PT Bathed + Hoyer Weight Obtained. No Neuro Δ's (0645) Report To 7A-7p Shift — JG

SEE CONTINUED NURSES' SUMMARY

27 - 180

4

See Admission Assessment database for initial admitting assessment

ASSESSMENT	AM	PM
MENTAL		
Alert	Sed	Sed
Cooperative/Uncooperative		
Anxious/Restless/Agitated		
Speech Clear/Slurred		Eff
PULMONARY		
Breath Sounds: Clear R/L	✓	✓
Crackles R/L		
Wheezes R/L		
Rhonchi R/L		Coarse
Diminished R/L		
Absent R/L		
Resp. Effort: Regular/Irregular	✓	✓
Unlabored/Labored	✓	✓
Accessory Muscle Use		YES
Symmetrical Chest Expansion	✓	YES
Denies/Admits SOB or Dyspnea		
Cough: Productive/Nonproductive		
Color		
Tracheostomy		
Cuff up/down	✓	✓
Tube secured in place	✓	YES
Ambu at bedside	✓	YES
ET tube: oral/nasal	✓	✓
# cm at teeth/lip	24	24
size	8.0	8.0
CHEST TUBES		
CT # 1 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 2 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 3 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 4 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		

ASSESSMENT	AM	PM
CARDIAC		
Apical Pulse Regular /Irregular	✓	✓
Capillary Refill: < 2 sec/>2 sec	✓	✓
Neck Veins: Flat/Distended	✓	✓
EKG Rhythm	SR+T	ST80
Lead	II	V
EKG Hi/Lo Alarms On at:	150/30	90/50
Pacer: Temporary/Permanent		
Insertion Depth (cm)		
Transvenous/External		
Epicardial Wires		
Pulse Generator On/Off		
Rate		
MA		
Demand/Asynchronous		
HEMODYNAMICS		
Transducers: Leveled with RA		
Transducers: Zeroed & Calibrated		
Transducers: 1000 U. Heparin		
Transducers: 500 CC. NS Flush		
A - Line Site:		
Proper Wave Form		
MAP HI/LO Alarms On at		
Drsg dry & Intact		
PA Catheter Site:		
Insertion Depth (cm)		
Proper Waveform		
Drsg Dry & Intact		
CVP Catheter Site:		
Proper Waveform		
Drsg Dry & Intact		
IABP Site:		
Ratio I:		
Proper Augmentation		
Alarm On		
Drsg Dry & Intact		
SKIN		
Intact/Break in Skin Surface*	✓	✓
Warm Cool	✓	✓
Dry/Clammy/Diaphoretic	✓	✓
Pink/Pale (✓ nailbeds/mucous membranes)		✓
Cyanotic/Flushed/Jaundiced		
Edema - Site	Generalized	Gen
+1 +2 +3 P=Pitting	2+	+2
GI - GU		
Urine Color	amb	Dk Yel.
Clear/Cloudy/Bloody	✓	✓
Voids/Foley/CBI	✓	✓
Abdomen: Soft/Firm	✓	✓
Flat/Distended	✓	✓
Nontender/Tender	✓	✓
Bowel Sounds: Present/Absent	✓	✓
Hypoactive/Hyperactive		
Expels Flatus		
NGT/PEG (Placement verified)	✓	
suction/clamped/feeding	✓	
Urostomy/Ileostomy/Colostomy		
Stoma Pink/Other		

ASSESSMENT	AM	PM
SURGICAL		
Incision #1 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
Incision #2 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
DRAINS		
Drain Tube - Site & Type:	Rectal	
Drainage: Sang/Serosang/Sero		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
IV ACCESSES		
IV Access: Site	(R)AC	RSC
Patent	✓	✓
IV Access: Site	(L)AC	LAC
Patent	✓	✓
IV Access: Site	R JL	RHA LAC
Patent	✓	✓
SAFETY		
Bed in Low Position	✓	✓
Call Light in Reach	✓	✓
Side Rails Up: Upper/Full	✓	✓
POTENTIAL FOR VIOLENCE	NO	
ASSESSORS		
Assessors Initials	AP PA	

AP

RN SIGNATURE: L Steen RN PA

36-24-04 |N| 11TH

CARDWELL, JOHN W

SZCZERBA, ARTHUR J 9061 ADM 7/16/01

DOB 9/01/61 039Y M

00011324092

UNITED REGIONAL HEALTH CARE SYSTEM

6

07-151

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

observed, deflated balloon, repositioned rectal tube & balloon reinflated, restraints on wrists removed during bath, CMS adequate — K — (2200) restraints reapplied VSS - assessment unchanged — K — (0000) Wrist restraints removed, CMS adequate, having periods of rapid shallow respirations & trembling of shoulders, when instructed to slow down his respirations pt seems to respond, VSS, restraints reapplied for skin integrity and d/t fact that pt is currently incarcerated — K — (0200) CMS √ and adequate VSS & distress observed — K — (0400) VSS, assessment unchanged — K — (0700) Report to am shift - C. Russell RN — K

☐ SEE CONTINUED NURSES' SUMMARY

07-152

4

See Admission Assessment database for initial admitting assessment

MENTAL	ASSESSMENT	AM	PM
	Alert	✳	✳
	Cooperative/Uncooperative		
	Anxious/Restless/Agitated		
	Speech Clear/Slurred		Eff
PULMONARY	Breath Sounds: Clear R/L		
	Crackles R/L		
	Wheezes R/L		
	Rhonchi R/L		
	bases Diminished sl. R/L		
	Absent R/L		
	Resp. Effort: Regular/Irregular		
	Unlabored/Labored		
	Accessory Muscle Use		yes
	Symmetrical Chest Expansion		
	Denies/Admits SOB or Dyspnea	Eff	Eff
	Cough: Productive/Nonproductive		
	Color		yel blad tinge
	Tracheostomy	ETT	ETT
	Cuff up/down		
	Tube secured in place	yes	yes
	Ambu at bedside	yes	yes
	ET tube: oral/nasal		
	# cm at teeth/lip	24	24
	size	#8	#8
CHEST TUBES	**CT # 1 site:**		
	Suction: # cm H_2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 2 site:		
	Suction: # cm H_2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 3 site:		
	Suction: # cm H_2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 4 site:		
	Suction: # cm H_2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		

CARDIAC	ASSESSMENT	AM	PM
	Apical Pulse Regular /Irregular	✓	✓
	Capillary Refill: < 2 sec/>2 sec	✓	✓
	Neck Veins: Flat/Distended	✓	✓
	EKG Rhythm	ST	ST
	Lead	II	II
	EKG Hi/Lo Alarms On at:	150/50	150/50
	Pacer: Temporary/Permanent		
	Insertion Depth (cm)		
	Transvenous/External		
	Epicardial Wires		
	Pulse Generator On/Off		
	Rate		
	MA		
	Demand/Asynchronous		
Transducers	Leveled with RA		
	Zeroed & Calibrated		
	1000 U. Heparin		
	500 CC. NS Flush		
HEMODYNAMICS	**A - Line Site:**		
	Proper Wave Form		
	MAP HI/LO Alarms On at		
	Drsg dry & Intact		
	PA Catheter Site:		
	Insertion Depth (cm)		
	Proper Waveform		
	Drsg Dry & Intact		
	CVP Catheter Site:		
	Proper Waveform		
	Drsg Dry & Intact		
	IABP Site:		
	Ratio I:		
	Proper Augmentation		
	Alarm On		
	Drsg Dry & Intact		
SKIN	Intact/Break in Skin Surface*	✓	✳
	Warm Cool	✓	✓
	Dry/Clammy/Diaphoretic	✓	✓
	Pink/Pale (✓ nailbeds/mucous membranes)	✓	
	Cyanotic/Flushed/Jaundiced		
	Edema - Site	extremities	ank
	+1 +2 +3 P=Pitting	1+	+2
GI - GU	Urine Color	orange	orange
	Clear/Cloudy/Bloody	✓	✓
	Voids/Foley/CBI	✓	✓
	Abdomen: Soft/Firm	✓	✓
	Flat/Distended	✓	✓
	Nontender/Tender	✓	✓
	Bowel Sounds: Present/Absent		✓
	Hypoactive/Hyperactive		
	Expels Flatus		—
	NGT/PEG (Placement verified)		✓
	suction/clamped/feeding		✓
	Urostomy/Ileostomy/Colostomy		
	Stoma Pink/Other		

SURGICAL	ASSESSMENT	AM	PM
	Incision #1 Site		
	Open to Air/Dressing		
	Dressing Dry & Intact /Drainage		
	Edges: Approximated /Open*		
	with: Staples/Sutures/Steri Strips		
	Redness/Induction/Swelling		
	Drainage: Sang/Serosang/Sero		
	Purulent		
	Amount: Sm/Mod/Lrg		
	Incision #2 Site		
	Open to Air/Dressing		
	Dressing Dry & Intact /Drainage		
	Edges: Approximated /Open*		
	with: Staples/Sutures/Steri Strips		
	Redness/Induction/Swelling		
	Drainage: Sang/Serosang/Sero		
	Purulent		
	Amount: Sm/Mod/Lrg		
DRAINS	Drain Tube - Site & Type:		
	Drainage: Sang/Serosang/Sero		
	Drain Tube - Site & Type:		
	Drainage: Sang/Serosang/Sero		
IV ACCESSES	IV Access: Site	RSC	RSC
	Patent		✓
	IV Access: Site	Lhand	LFA
	Patent		✓
	IV Access: Site	RFA	RA
	Patent		✓
SAFETY	Bed in Low Position	✓	✓
	Call Light in Reach	✓	✓
	Side Rails Up: Upper/Full	✓	✓
	POTENTIAL FOR VIOLENCE		WD
ASSESSORS	Assessors Initials	AP	
		PA	W

RN SIGNATURE

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092

07-153

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

1930 cont Perp. IV lns flushed and are patent. Guards @ BS x 3. Ø s/s of distress noted. Will cont. to monitor (P)
2030 Family members @ BS x 2. Cont. to be restless - moving - fighting vent. Red Diprivan to 40 cc/hr or 70 mcg. VSS. Will cont. to monitor (P) 2200 Turned pt. to (R) side - repositioned for comfort. Restraints released during turning. CMS intact. Pulses palp. oral care provided. Diprivan ↑ to 45cc/hr or 78 mcg. Temp @ 100°. Cooling blanket on. VSS. Guards remain @ BS (D) 2350 Pt. turned to back. Repositioned for comfort. Restraints released during turning. CMS intact. Pulses palp. NO/RTO good. FBS is 122. Ø coverage needed. Temp @ 99°. VSS agitated @ 45cc/hr of Diprivan. VSS. Oral care provided. Ø s/s of distress noted. (P)
0145 Pt. turned to (D) side. Repositioned for comfort. VSS. Ø Δs in ECG. Restraints released during repositioning. CMS intact. Pulses palp. Temp @ 98.4. Cooling blanket off. Calm @ this time. Oral care/suct. provided. Ø Δs assessment. Guards @ BS x 3. Will cont. to monitor (P) 0350 Pt. bathed and linen changed @ this time. Oral care and foley care provided. Suct. oral airway. Restraints released during bath and re-applied p turning/re-positioned. Pt. tolerated well. VSS. Ø Δs in ECG. Temp good. Cooling blanket remains off. Ø s/s of distress noted (P) 0530 Pt. repositioned for comfort. Restraints released during turning - re-applied when repositioned. CMS intact. All pulses palp. Attempted lite Diprivan - not tolerating well. Remains @ 78 mcg. VSS. Ø Δs in ECG. Guards remain @ BS. (P) 0610 Ø Δs in status. Pt. resting comfortably. Calm @ present. VSS. Ø s/s of distress noted. Guards @ BS x 3. (A)

SEE CONTINUED NURSES' SUMMARY

27-154

4

See Admission Assessment database for initial admitting assessment

ASSESSMENT	AM	PM
MENTAL		
Alert	A	*
Cooperative/Uncooperative		
Anxious/Restless/Agitated		
Speech Clear/Slurred		ET
PULMONARY		
Breath Sounds: Clear R/L	✓	✓
Crackles R/L		
Wheezes R/L		
Rhonchi R/L		
Diminished R/L		✓
Absent R/L		
Resp. Effort: Regular/Irregular	✓	✓
Unlabored/Labored	✓	✓
Accessory Muscle Use	No	Yes
Symmetrical Chest Expansion	Yes	Yes
Denies/Admits SOB or Dyspnea	ET	ET
Cough: Productive/Nonproductive		
Color		—
Tracheostomy	ET	ET
Cuff up/down	✓	✓
Tube secured in place	Yes	Yes
Ambu at bedside	Yes	Yes
ET tube: oral/nasal	✓	✓
# cm at teeth/lip	24 up	24
size	8	#8
CHEST TUBES		
CT # 1 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 2 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 3 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 4 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		

ASSESSMENT	AM	PM
CARDIAC		
Apical Pulse Regular /Irregular	✓	✓
Capillary Refill: < 2 sec/>2 sec	✓	✓
Neck Veins: Flat/Distended	✓	✓
EKG Rhythm	ST	ST
Lead	II	II
EKG Hi/Lo Alarms On at:	150/50	150/50
Pacer: Temporary/Permanent		
Insertion Depth (cm)		
Transvenous/External		
Epicardial Wires		
Pulse Generator On/Off		
Rate		
MA		
Demand/Asynchronous		
Transducers: Leveled with RA		
Transducers: Zeroed & Calibrated		
Transducers: 1000 U. Heparin		
Transducers: 500 CC. NS Flush		
HEMODYNAMICS		
A - Line Site:		
Proper Wave Form		
MAP HI/LO Alarms On at		
Drsg dry & Intact		
PA Catheter Site:		
Insertion Depth (cm)		
Proper Waveform		
Drsg Dry & Intact		
CVP Catheter Site:		
Proper Waveform		
Drsg Dry & Intact		
IABP Site:		
Ratio I:		
Proper Augmentation		
Alarm On		
Drsg Dry & Intact		
SKIN		
Intact/Break in Skin Surface*		✓
Warm Cool	✓	✓
Dry/Clammy/Diaphoretic	✓	✓
Pink/Pale (✓ nailbeds/mucous membranes)	✓	✓
Cyanotic/Flushed/Jaundiced		
Edema - Site	Sacral Area	Sacral Area
+1 +2 +3 P=Pitting	+2	+2
GI - GU		
Urine Color	Orange	✓
Clear/Cloudy/Bloody	✓	✓
Voids/Foley/CBI	✓	✓
Abdomen: Soft/Firm	✓	✓
Flat/Distended	✓	✓
Nontender/Tender	✓	✓
Bowel Sounds: Present/Absent	✓	✓
Hypoactive/Hyperactive	✓	✓
Expels Flatus		—
NGT/PEG (Placement verified)	✓	✓
suction/clamped/feeding	✓	✓
Urostomy/Ileostomy/Colostomy	✓	✓
Stoma Pink/Other		

ASSESSMENT	AM	PM
SURGICAL		
Incision #1 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
Incision #2 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
DRAINS		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
IV ACCESSES		
IV Access: Site (L) SC TC	✓	(R) S
Patent	✓	✓
IV Access: Site (L) hand (L) AC	HL	✓
Patent		✓
IV Access: Site (R) AC	HL	✓
Patent		✓
SAFETY		
Bed in Low Position	✓	✓
Call Light in Reach	✓	✓
Side Rails Up: Upper/Full	✓	✓
POTENTIAL FOR VIOLENCE		no
ASSESSORS		
Assessors Initials	AP	
	PA	

K Gavin RN @ 0800 AP
RN SIGNATURE Renee Buselli RN PA

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y
00011324092 M

UNITED REGIONAL HEALTH CARE SYSTEM

E

97-153

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

1945 cont. and pulls head away from ETT mvmt. VSS. O2 sat @ 93% on vent. ETT. ECG tracing ST. Restraints (soft) on to bilat. wrists. Released during repositioning. CMS intact. All pulses palp. Scratches to L ext. CMS intact. Lungs relatively clear, diminished to the bases. BS(B) - hyperactive. Foley and RT op excellent. Abdomen firm and distended. Nrs. aware. Gen. edema present all over. NS infusing @ difficulty to (R)SC. BLS x2 (L) arm intact (R) AC IV intact. Oral care provided. (accurate) used pan to eyes (periorbital edema). ϕ S/S of distress noted. HOB & SBS. Lake entry: OGT to ↓ suct. placement verified. Suct. ETT - ϕ secretions. Oral airway suct. - small amt yell-blood tinged sputum received. will cont. to monitor @ 2130 Pt. turned / repositioned for comfort. Restraints released (wrists) during repositioning. CMS intact. Pulses palp. VSS. Oral care provided. Suct. oral airway. Orders received from Dr. Patel to start SSC @ 0000. Resps even and unlabored. Guards @ BS x3. will cont to monitor (R) — 2335 Pt. temp ↓. Cooling blanket off. Repositioned / turned for comfort. Oral care provided. FBS is 198. 3u regular insulin given SQ. Diprivan ↑ 4.5 u/l. / Norcuron + 10cc/l. Pt pt-agitation - red abdominal breathing & fighting vent. VSS - ϕ Δs in ECG. @ 0235 Temp ↑. Cooling blanket back on. Repositioned / turned for comfort. oral care provided. Cont. Abdominal breathing. Sats ↓. ↑ Diprivan to 10cc/l. Restraints released during repositioning. CMS intact. VSS @ 0300 Pt. starting to settle down. Temp unchanged. Guards @ BS x3. VSS. (R) 0430 Pt. bathed and linens did @ this time. oral care and foley care provided. Restraints released during bath and repositioning. CMS intact. All pulses palp. Sats and temp improving. VSS. oral suct done. (R) SC cl Dressing did. ϕ S/S of distress noted. @ 0550 Temp @ 99b. Resting comfortably. VSS. Resps even and unlabored. Repositioned for comfort ϕ S/S of distress noted @

SEE CONTINUED NURSES' SUMMARY

07-154

See Admission Assessment database for initial admitting assessment

ASSESSMENT	AM	PM
MENTAL		
Alert		*
Cooperative/Uncooperative		*
Anxious/Restless/Agitated		0
Speech Clear/Slurred		Eff
PULMONARY		
Breath Sounds: Clear R/L		
Crackles R/L		
Wheezes R/L	✓	✓
Rhonchi R/L		✓ ✓
Diminished R/L		
Absent R/L		
Resp. Effort: Regular/Irregular	✓	✓
Unlabored/Labored	✓	✓
Accessory Muscle Use	No	0
Symmetrical Chest Expansion	✓	✓
Denies/Admits SOB or Dyspnea		*
Cough: Productive/Nonproductive		✓
Color		Yel/Blue
Tracheostomy		—
Cuff up/down	✓	✓
Tube secured in place	✓	✓
Ambu at bedside	✓	yes
ET tube: oral/nasal	✓	✓
# cm at teeth/lip	25	25
size	7.0	#8
CHEST TUBES		
CT # 1 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 2 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 3 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 4 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		

ASSESSMENT	AM	PM
CARDIAC		
Apical Pulse Regular /Irregular	✓	✓
Capillary Refill: < 2 sec/>2 sec	✓	✓
Neck Veins: Flat/Distended	✓	✓
EKG Rhythm	ST	ST
Lead	II	II
EKG Hi/Lo Alarms On at:	50	150/50
Pacer: Temporary/Permanent		
Insertion Depth (cm)		
Transvenous/External		
Epicardial Wires		
Pulse Generator On/Off		
Rate		
MA		
Demand/Asynchronous		
Transducers: Leveled with RA		
Zeroed & Calibrated		
1000 U. Heparin		
500 CC. NS Flush		
HEMODYNAMICS		
A - Line Site:		
Proper Wave Form		
MAP HI/LO Alarms On at		
Drsg dry & Intact		
PA Catheter Site:		
Insertion Depth (cm)		
Proper Waveform		
Drsg Dry & Intact		
CVP Catheter Site:		
Proper Waveform		
Drsg Dry & Intact		
IABP Site:		
Ratio I:		
Proper Augmentation		
Alarm On		
Drsg Dry & Intact		
SKIN		
Intact/Break in Skin Surface*	✓	✓
Warm Cool		
Dry/Clammy/Diaphoretic	✓	✓
Pink/Pale (✓ nailbeds/mucous membranes)	✓	✓
Cyanotic/Flushed/Jaundiced		
Edema - Site		generalized
+1 +2 +3 P=Pitting		+2
GI - GU		
Urine Color	Amber	✓
Clear/Cloudy/Bloody	✓	✓
Voids/Foley/CBI	✓	✓
Abdomen: Soft/Firm	✓	✓
Flat/Distended	✓	✓
Nontender/Tender	✓	✓
Bowel Sounds: Present/Absent	✓	✓
Hypoactive/Hyperactive	✓	✓
Expels Flatus		—
Rectal Tube	✓	✓
NGT/PEG (Placement verified)	✓	✓
suction/clamped/feeding	✓	✓
Urostomy/Ileostomy/Colostomy		
Stoma Pink/Other		

ASSESSMENT	AM	PM
SURGICAL INCISIONS		
Incision #1 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
Incision #2 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
DRAINS		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
IV ACCESSES		
IV Access: Site Rt Subc TLC	✓	✓
Patent	✓	✓
IV Access: Site Rt p:ph v2	✓	(L)Ple
Patent	✓	✓
IV Access: Site Lt Ac	✓	(R) A
Patent	✓	✓
SAFETY		
Bed in Low Position	✓	✓
Call Light in Reach	✓	✓
Side Rails Up: Upper/Full	✓	✓
POTENTIAL FOR VIOLENCE		no
ASSESSORS		
Assessors Initials	AP Thom	
	PA W	
RN SIGNATURE	AP	
R Brusellin	PA	

UNITED REGIONAL HEALTH CARE SYSTEM
36-24-04 |N| 11TH
CARDWELL,JOHN W
SZCZERBA, ARTHUR J 9081 ADM 7/10/01
DOB 9/01/61 039Y M
00011324092

6

27-157

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

1450 ETT retaped by Resps tx x2. Remains 25 @ the lip. oral care provided -Suct. oral cavity - Blood tinged sputum received. Ø Δs in status @ 2115 Pt. turned/repositioned for comfort. Restraints to wrists released. CMS intact. Reapplied p positioning. Temp stable. oral care provided. Suct. oral airway. VSS. @ 2300 Guards remain @ BS x3. VSS. Ø Δs in ECG. Pt. turned/repositioned for comfort. Restraints released. CMS intact. Passive ROM done. Re-applied p positioned. Ø SIS of distress noted. HOB & SRS ↑ @ 0035 FBS is 212. Ø coverage ordered. Turned/re-positioned for comfort. Restraints released (bilat. wrists) CMS intact. Re-applied when care complete. oral care provided. Suct. for comfort - little recvd. Temp @ 99°. Foley op and RT op good. Ø Δs in status. Guards @ BS. HOB & SRS ↑. @ 0700 Pt. turned/repositioned for comfort. Restraints released. CMS intact (bilat wrists). All pulses palp. Restraints reapp p care complete. Temp @ 98°. Ø Δs in status. VSS. HOB & SRS ↑ c Guards @ BS. Will cont. to monitor @ 0330 Ø Δs in status. oral care provided. Repositioned/turned for comfort. Wrist restraints removed during repositioning. Re-applied p. VSS. Ø Δs in ECG. Guards @ BS. @ 0520 Pt. bathed and linens Sed @ this time. Hoyered for wt. Restraints removed during bath/wt. CMS intact. Oral care and foley care provided. VSS. Am labs drawn. Ho/RT excellent. FBS @ 222. HOB & SRS ↑. Ø S/S of distress noted. @ 0800 Ø Δs in status. Ø S/S of distress noted. Dr. Koushik here. Labs and chart reviewed. Temp Δs and FBS ↑ reported. Ø orders received. Guards @ BS. VSS. ECG tracing ST & ectopy @

☐ SEE CONTINUED NURSES' SUMMARY

27-157

4

27-158

27-159

See Admission Assessment database for initial admitting assessment

ASSESSMENT	AM	PM
MENTAL		
Alert		
Cooperative/Uncooperative		
Anxious/Restless/Agitated		
Speech Clear/Slurred		
PULMONARY		
Breath Sounds: Clear R/L		
Crackles R/L		
Wheezes R/L		
Rhonchi R/L		
Diminished R/L		
Absent R/L		
Resp. Effort: Regular/Irregular		
Unlabored/Labored		
Accessory Muscle Use		
Symmetrical Chest Expansion		
Denies/Admits SOB or Dyspnea		
Cough: Productive/Nonproductive		
Color		
Tracheostomy		
Cuff up/down		
Tube secured in place		
Ambu at bedside		
ET tube: oral/nasal		
# cm at teeth/lip		
size		
CHEST TUBES		
CT-# 1 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 2 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 3 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 4 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		

ASSESSMENT	AM	PM
CARDIAC		
Apical Pulse Regular /Irregular		
Capillary Refill: < 2 sec/>2 sec		
Neck Veins: Flat/Distended		
EKG Rhythm	ST	ST
Lead	II	II
EKG Hi/Lo Alarms On at:	50/150	50/150
Pacer: Temporary/Permanent		
Insertion Depth (cm)		
Transvenous/External		
Epicardial Wires		
Pulse Generator On/Off		
Rate		
MA		
Demand/Asynchronous		
Transducers: Leveled with RA		
Zeroed & Calibrated		
1000 U. Heparin		
500 CC. NS Flush		
HEMODYNAMICS		
A - Line Site:		
Proper Wave Form		
MAP HI/LO Alarms On at		
Drsg dry & Intact		
PA Catheter Site:		
Insertion Depth (cm)		
Proper Waveform		
Drsg Dry & Intact		
CVP Catheter Site:		
Proper Waveform		
Drsg Dry & Intact		
IABP Site:		
Ratio I:		
Proper Augmentation		
Alarm On		
Drsg Dry & Intact		
SKIN		
Intact/Break in Skin Surface*		
Warm Cool		
Dry/Clammy/Diaphoretic		
Pink/Pale (✔ nailbeds/mucous membranes)		
Cyanotic/Flushed/Jaundiced		
Edema - Site		
+1 +2 +3 P=Pitting		
GI - GU		
Urine Color		
Clear/Cloudy/Bloody		
Voids/Foley/CBI		
Abdomen: Soft/Firm		
Flat/Distended		
Nontender/Tender		
Bowel Sounds: Present/Absent		
Hypoactive/Hyperactive		
Expels Flatus		
NGT/PEG (Placement verified)		
suction/clamped/feeding		
Urostomy/Ileostomy/Colostomy		
Stoma Pink/Other		

ASSESSMENT	AM	PM
SURGICAL		
Incision #1 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
Incision #2 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
DRAINS		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
IV ACCESSES		
IV Access: Site (L) ac		
Patent		
IV Access: Site (R) ac		
Patent		
IV Access: Site (L) hand		
Patent		
RSC		
SAFETY		
Bed in Low Position		
Call Light in Reach		
Side Rails Up: Upper/Full		
POTENTIAL FOR VIOLENCE	NO	
ASSESSORS		
Assessors Initials	AP	
	PA	
RN SIGNATURE	AP	
	PA	

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W
SZCZERBA, ARTHUR J 9061 ADM 7/16/01
DOB 9/01/61 039Y M
00011324092

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D7-160

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

1900 cont ABD Round/firm. Rectal tube in place. Small amount of Brown Drainage. Foley cath in place - amber color urine. Cooling blanket working under pt. (R) SC Lv site infusing IV fluids ē diff. Narcan has been turned ~~down~~ ~~being~~ off By day shift. Diprivan on low dose. Soft cloth restraint on pt for protection of pt from pulling out ET tube. Appears to be in Ø distress at this time. ——— Ozor N

(2100) Pt becoming anxious, ABD Breathing. Suctioned several times - lg amount Red/Yellow tinged Secretions. Diprivan ↑/Narcan on. Pt is calming. Will monitor BP. ——— Ozor

(0000) Pt sedated ō Respiration nonlabored. Ozor RN. (0300) Pt Shaved, Bathed, Foley Care, Bed linens Δ'd. Mouth care given. Pt continues to be sedated. Ozor RN

(0500) Ø change in assessment. Ozor N

☐ SEE CONTINUED NURSES' SUMMARY

27-161

27-162

See Admission Assessment database for initial admitting assessment

ASSESSMENT	AM	PM
MENTAL		
Alert UNRESPONSIVE		
Cooperative/Uncooperative		
Anxious/Restless/Agitated		
Speech Clear/Slurred		
PULMONARY		
Breath Sounds: Clear R/L		
Crackles R/L		
Wheezes R/L		
Rhonchi R/L		
Diminished R/L		
Absent R/L		
Resp. Effort: Regular/Irregular		
Unlabored/Labored		
Accessory Muscle Use		
Symmetrical Chest Expansion		
Denies/Admits SOB or Dyspnea		
Cough: Productive/Nonproductive		
Color		
Tracheostomy		
Cuff up/down		
Tube secured in place		
Ambu at bedside		
ET tube: oral/nasal		
# cm at teeth/lip		
size		
CHEST TUBES		
CT # 1 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 2 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 3 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		
CT # 4 site:		
Suction: # cm H_2O/Gravity		
Bubbling		
Fluctuation in chamber		
Crepitus		
Drainage: Sang/Serosang/Sero		
Tubing Connections Secure		
CT Dressing Dry & Intact		

ASSESSMENT	AM	PM
CARDIAC		
Apical Pulse Regular /Irregular		
Capillary Refill: < 2 sec/>2 sec		
Neck Veins: Flat/Distended		
EKG Rhythm		
Lead		
EKG Hi/Lo Alarms On at:		
Pacer: Temporary/Permanent		
Insertion Depth (cm)		
Transvenous/External		
Epicardial Wires		
Pulse Generator On/Off		
Rate		
MA		
Demand/Asynchronous		
Transducers: Leveled with RA		
Transducers: Zeroed & Calibrated		
Transducers: 1000 U. Heparin		
Transducers: 500 CC. NS Flush		
HEMODYNAMICS		
A - Line Site:		
Proper Wave Form		
MAP HI/LO Alarms On at		
Drsg dry & Intact		
PA Catheter Site:		
Insertion Depth (cm)		
Proper Waveform		
Drsg Dry & Intact		
CVP Catheter Site:		
Proper Waveform		
Drsg Dry & Intact		
IABP Site:		
Ratio I:		
Proper Augmentation		
Alarm On		
Drsg Dry & Intact		
SKIN		
Intact/Break in Skin Surface*		
Warm Cool		
Dry/Clammy/Diaphoretic		
Pink/Pale (✔ nailbeds/mucous membranes)		
Cyanotic/Flushed/Jaundiced		
Edema - Site		
+1 +2 +3 P=Pitting		
GI - GU		
Urine Color		
Clear/Cloudy/Bloody		
Voids/Foley/CBI		
Abdomen: Soft/Firm		
Flat/Distended		
Nontender/Tender		
Bowel Sounds: Present/Absent		
Hypoactive/Hyperactive		
Expels Flatus		
NGT/PEG (Placement verified)		
suction/clamped/feeding		
Urostomy/Ileostomy/Colostomy		
Stoma Pink/Other		

ASSESSMENT	AM	PM
SURGICAL		
Incision #1 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
Incision #2 Site		
Open to Air/Dressing		
Dressing Dry & Intact /Drainage		
Edges: Approximated /Open*		
with: Staples/Sutures/Steri Strips		
Redness/Induction/Swelling		
Drainage: Sang/Serosang/Sero		
Purulent		
Amount: Sm/Mod/Lrg		
DRAINS		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
Drain Tube - Site & Type:		
Drainage: Sang/Serosang/Sero		
IV ACCESSES		
IV Access: Site		
Patent		
IV Access: Site		
Patent		
IV Access: Site		
Patent		
SAFETY		
Bed in Low Position		
Call Light in Reach		
Side Rails Up: Upper/Full		
POTENTIAL FOR VIOLENCE		

ASSESSORS

Assessors Initials AP PA

IN SIGNATURE AP PA

UNITED REGIONAL HEALTH CARE SYSTEM 11TH

36-24-04 |N|

CARDWELL, JOHN W

SZCZERBA, ARTHUR J 9061 ADM 7/16/01

DOB 9/01/61 039Y

00011324092 M

6

7-7-16

NURSES NOTES (CONTINUED FROM REVERSE SIDE)

1500 Dopamine ↑ 6.5 mcg. agitation continues. BP improves. T 98.6. follows commands [signature]
1600 Agitated BP stable continues to follow commands [signature]
1700 remains responsive [signature]
1800 Ø Δ in assessment [signature]
2000 Initial assessment done & recorded on flowsheet. Pt alert, FC, nods head appropriately. Pupils slightly unequal, (L) only sluggishly reactive, (R) briskly reactive. Pt is on cooling blanket, T 98.8 @ this time. Denies pain. Fairly calm. Explained tubes & situation to pt. Episodes of restlessness. Monitor shows ST 100-110. Foley cath intact. Rectal tube intact. [signature] Edwards RN
2200 VS 98.5-108-(38-42)- 70/0. Dr Chakrala here for consult. Dr PEF Notified that BP's have been difficult to find even c doppler. New orders rec'd. [signature] Edwards RN 0000 Norcuron 5mg IVP given while Dr Chak in room. Pt has been A'd to CMV mode on vent. [signature] Edwards RN
0100 RT drew repeat ABG's, called to Dr Chak. New orders rec'd. [signature] Edwards RN 0145 1 amp NaHCO3 has been given. BPs remain low between 80-100 systolic. Pt is now paralyzed c Norcuron & Ativan (sedated). [signature] Edwards RN 0400 No Δ in status. BP's continue to fluctuate. Urine OP fair. [signature] Edwards RN 0630 Bed bath, Foley care, oral care, ✓ lines & done. Pt totally paralyzed. Pupils unchanged from earlier. [signature] Edwards RN

☐ SEE CONTINUED NURSES' SUMMARY

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See Admission Assessment database for initial admitting assessment

MENTAL	ASSESSMENT	AM	PM
	Alert		*
	Cooperative/Uncooperative		
	Anxious/Restless/Agitated		
	Speech Clear/Slurred		

PULMONARY	ASSESSMENT	AM	PM
	Breath Sounds: Clear R/L		
	Crackles R/L		
	Wheezes R/L		
	Rhonchi R/L		✓
	Diminished R/L		
	Absent R/L		
	Resp. Effort: Regular/Irregular		✓
	Unlabored/Labored		✓
	Accessory Muscle Use		YES
	Symmetrical Chest Expansion		YES
	Denies/Admits SOB or Dyspnea		✓
	Cough: Productive/Nonproductive		✓
	Color		bloody
	Tracheostomy		
	Cuff up/down		✓
	Tube secured in place		YES
	Ambu at bedside		YES
	ET tube: oral/nasal		✓
	# cm at teeth/lip teeth		23
	size		8.0

CHEST TUBES	ASSESSMENT	AM	PM
	CT # 1 site:		
	Suction: # cm H_2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 2 site:		
	Suction: # cm H_2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 3 site:		
	Suction: # cm H_2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		
	CT # 4 site:		
	Suction: # cm H_2O/Gravity		
	Bubbling		
	Fluctuation in chamber		
	Crepitus		
	Drainage: Sang/Serosang/Sero		
	Tubing Connections Secure		
	CT Dressing Dry & Intact		

CARDIAC	ASSESSMENT	AM	PM
	Apical Pulse Regular /Irregular		
	Capillary Refill: < 2 sec/>2 sec		
	Neck Veins: Flat/Distended		✓
	EKG Rhythm		ST
	Lead		II
	EKG Hi/Lo Alarms On at:		150/50
	Pacer: Temporary/Permanent		
	Insertion Depth (cm)		
	Transvenous/External		
	Epicardial Wires		
	Pulse Generator On/Off		
	Rate		
	MA		
	Demand/Asynchronous		

HEMODYNAMICS	ASSESSMENT	AM	PM
Transducers	Leveled with RA		
	Zeroed & Calibrated		
	1000 U. Heparin		
	500 CC. NS Flush		
	A - Line Site:		
	Proper Wave Form		
	MAP HI/LO Alarms On at		
	Drsg dry & Intact		
	PA Catheter Site:		
	Insertion Depth (cm)		
	Proper Waveform		
	Drsg Dry & Intact		
	CVP Catheter Site:		
	Proper Waveform		
	Drsg Dry & Intact		
	IABP Site:		
	Ratio I:		
	Proper Augmentation		
	Alarm On		
	Drsg Dry & Intact		

SKIN	ASSESSMENT	AM	PM
	Intact/Break in Skin Surface*		✓
	Warm Cool		✓
	Dry/Clammy/Diaphoretic		✓
	Pink/Pale (✓ nailbeds/mucous membranes)		✓
	Cyanotic/Flushed/Jaundiced		
	Edema - Site		
	+1 +2 +3 P=Pitting		

GI, GU	ASSESSMENT	AM	PM
	Urine Color		Amber
	Clear/Cloudy/Bloody		✓
	Voids/Foley/CBI		✓
	Abdomen: Soft/Firm		✓
	Flat/Distended		✓
	Nontender/Tender		✓
	Bowel Sounds: Present/Absent		✓
	Hypoactive/Hyperactive		
	Expels Flatus		
	NGT/PEG (Placement verified)		✓
	suction/clamped/feeding		✓
	Urostomy/Ileostomy/Colostomy		
	Stoma Pink/Other		

SURGICAL	ASSESSMENT	AM	PM
	Incision #1 Site		
	Open to Air/Dressing		
	Dressing Dry & Intact /Drainage		
	Edges: Approximated /Open*		
	with: Staples/Sutures/Steri Strips		
	Redness/Induction/Swelling		
	Drainage: Sang/Serosang/Sero		
	Purulent		
	Amount: Sm/Mod/Lrg		
	Incision #2 Site		
	Open to Air/Dressing		
	Dressing Dry & Intact /Drainage		
	Edges: Approximated /Open*		
	with: Staples/Sutures/Steri Strips		
	Redness/Induction/Swelling		
	Drainage: Sang/Serosang/Sero		
	Purulent		
	Amount: Sm/Mod/Lrg		

DRAINS	ASSESSMENT	AM	PM
	Drain Tube - Site & Type:		
	Drainage: Sang/Serosang/Sero		
	Drain Tube - Site & Type:		
	Drainage: Sang/Serosang/Sero		

IV ACCESSES	ASSESSMENT	AM	PM
	IV Access: Site		LAC
	Patent		✓
	IV Access: Site		LHA
	Patent		✓
	IV Access: Site		RAC
	Patent		✓

SAFETY	ASSESSMENT	AM	PM
	Bed in Low Position		✓
	Call Light in Reach		✓
	Side Rails Up: Upper/Full		✓
	POTENTIAL FOR VIOLENCE		NO

ASSESSORS		AM	PM
	Assessors Initials	AP	
		PA	
	RN SIGNATURE R. Steen RN	AP	
		PA	

PATIENT ID LABEL

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NURSES NOTES (CONTINUED FROM REVERSE SIDE)

SEE CONTINUED NURSES' SUMMARY

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